Inspection Report

We are the regulator: *Our job is to check whether hospitals, care homes and care services are meeting essential standards.*

Charter Care (West Midlands) Limited (B69)

84 Birmingham Street, Oldbury, B69 4EB

Tel: 01215447600

Date of Inspections: 15 November 2013
29 October 2013

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We inspected the following standards as part of a routine inspection. This is what we found:

Care and welfare of people who use services	✖ Action needed
Safeguarding people who use services from abuse	✖ Action needed
Cleanliness and infection control	✓ Met this standard
Staffing	✓ Met this standard
Assessing and monitoring the quality of service provision	✖ Action needed

Details about this location

Registered Provider	Charter Care (West Midlands) Limited
Registered Manager	Mr. Mark Casey
Overview of the service	This is a domiciliary care agency that is registered to supply personal care to people in their own home. The agency offices are located in the Borough of Sandwell.
Type of service	Domiciliary care service
Regulated activity	Personal care

Contents

When you read this report, you may find it useful to read the sections towards the back called 'About CQC inspections' and 'How we define our judgements'.

Summary of this inspection

Why we carried out this inspection

This was a routine inspection to check that essential standards of quality and safety referred to on the front page were being met. We sometimes describe this as a scheduled inspection.

This was an announced inspection.

How we carried out this inspection

We looked at the personal care or treatment records of people who use the service, carried out a visit on 29 October 2013 and 15 November 2013, checked how people were cared for at each stage of their treatment and care and talked with people who use the service. We talked with carers and / or family members, talked with staff and reviewed information sent to us by commissioners of services.

What people told us and what we found

During our inspection we spoke with four people that used the service, the relatives of 10 other people, the manager, deputy manager and seven care workers.

Most people told us they were happy with the service and felt their needs were being met. One person told us, "Very good care." We found that care was not planned and delivered in a way that was intended to ensure people's safety and welfare.

Everyone that we spoke with felt they were safe with the staff that visited them. We found that people who used the service were not protected from the risk of abuse, because staff had failed to act in accordance with the provider's procedures.

People using the service had no concerns about infection control and we found that people were protected from the risk of infection because appropriate guidance had been followed.

Everyone that we spoke with felt that the service was reliable. We found that there were enough staff to meet people's needs.

The majority of the people that we spoke with were satisfied with the standard of service that they received. A relative told us, "No concerns about the care at all, they have been very good with her." However, we found that the provider did not have an effective system to regularly assess and monitor the quality of service that people received.

You can see our judgements on the front page of this report.

What we have told the provider to do

We have asked the provider to send us a report by 17 December 2013, setting out the action they will take to meet the standards. We will check to make sure that this action is taken.

Where providers are not meeting essential standards, we have a range of enforcement powers we can use to protect the health, safety and welfare of people who use this service (and others, where appropriate). When we propose to take enforcement action, our decision is open to challenge by the provider through a variety of internal and external appeal processes. We will publish a further report on any action we take.

More information about the provider

Please see our website www.cqc.org.uk for more information, including our most recent judgements against the essential standards. You can contact us using the telephone number on the back of the report if you have additional questions.

There is a glossary at the back of this report which has definitions for words and phrases we use in the report.

Our judgements for each standard inspected

Care and welfare of people who use services ✖ Action needed

People should get safe and appropriate care that meets their needs and supports their rights

Our judgement

The provider was not meeting this standard.

Care was not planned and delivered in a way that was intended to ensure people's safety and welfare.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

We spoke with four people that used the service and the relatives of 10 other people. Overall most people were happy with the service and felt their needs were being met. One person told us, "Very good care." A relative told us, "The service is very good, no problems." Although some people felt that there wasn't enough time allocated for staff to support them.

We looked at the care records of five people that used the service. We saw that all but one record contained a summary of the needs assessment completed by a social worker. We saw that care plans and risk assessments were available on each record. The provider had recently introduced a new care planning process, so we asked staff how effective these were. Staff spoken with had identified that people's health needs were not included in the new care plans. One staff told us that they needed to call the emergency services for a person who was unwell. The person had a health condition that the member of staff was unaware of as this information was not included in the care plan, so staff would be unable to pass key information on to support the person's needs. Staff said that they had reported this to the manager. We spoke with the manager who said that he was aware of this. However, no changes had been made to the care planning process that we saw. This meant that staff would not be able to support people effectively.

One person told us that their relative needs had changed and they had told the office, yet staff that visited them were not aware of the changes. One person told us, "I told charter care that the needs had changed and she now has dementia, but no one has been out to review the changes." Some staff told us that care plans and risk assessments were not always available in the homes for new people using the service and they were not always told about the needs of people before they visited. Three relatives told us that they frequently found medication on the floor, even though the care plan stated that staff were to ensure that medicines were taken. One person told us that their relative was being left

in bed for long periods of time and had pressure ulcers. They said their only concerns were they have asked for change in times of visits, so that their relative could spend less time in bed, and this had not been done. Most people told us that they were treated with dignity. However, a relative told us, "There is an issue with dignity. Staff changes her in the living room with the curtains and door open, anybody could walk in." This indicated that some people's needs were not being reviewed and updated as they should and therefore their needs were not always met with dignity and respect.

Safeguarding people who use services from abuse ✖ Action needed

People should be protected from abuse and staff should respect their human rights

Our judgement

The provider was not meeting this standard.

People who used the service were not protected from the risk of abuse, because staff had failed to act in accordance with the provider's procedures.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

All of the people that we spoke with felt they were safe with the staff that visited them. A relative told us, "I have no concerns about her safety."

The provider generally kept us informed of any matters of concerns that relates to the protection of people that used the service.

Before we inspected the service we received information of concern about a member of staff who was allegedly neglecting people that used the service. We were told that staff at the service was aware of issues pertaining to this member of staff and had failed to take adequate action. Due to this information we brought our scheduled inspection forward.

When we inspected the service we looked at any concerns received by the provider about this member of staff. We saw that there was information which indicated that the staff member had been suspended from duty for neglect. However, the manager could not give an account of the allegations and there were no records to show that any investigation had been undertaken. This meant that the provider had failed to demonstrate that adequate procedures were followed to ensure that people using the service were protected from harm in this instance.

However, Immediately following our inspection visit to the service, relatives and the manager told us that the member of staff had been suspended for allegations of mistreating people that used the service and that the situation had been on-going for a while and that staff were aware and had failed to raise concerns.

We spoke with seven care staff all knew about the whistleblowing procedures and said they knew how to use it, however, some staff said they wouldn't feel comfortable using it. All staff spoken with knew how to report safeguarding concerns in line with the provider's

policy, and said they had received training and updated training in safeguarding vulnerable adults. This meant that whilst staff were aware of the procedures, they failed in their duty to report information that put people that used the service at risk of harm.

Cleanliness and infection control ✓ Met this standard

People should be cared for in a clean environment and protected from the risk of infection

Our judgement

The provider was meeting this standard.

People were protected from the risk of infection because appropriate guidance had been followed.

Reasons for our judgement

All of the people that we spoke with told us that the staff that visited them always wore gloves and aprons when providing personal care and had no concerns about infection prevention and control.

At our last inspection we identified concerns with infection control processes. During this inspection we checked to see what actions the provider had taken to become compliant with the regulations.

We saw that the provider now had the appropriate guidance on infection control. A lead person for infection control had been appointed. Infection control formed part of the core training for all staff. This meant that the appropriate guidance was now in place for staff to follow.

Staffing ✓ Met this standard

There should be enough members of staff to keep people safe and meet their health and welfare needs

Our judgement

The provider was meeting this standard.

There were enough staff to meet people's needs.

Reasons for our judgement

Most people that we spoke with said that the service was fairly reliable, and that visits were not usually missed.

Before we inspected we received a concern that staff were working excessive of numbers of hours that could impact on how people were being cared for. All the staff we spoke with said that that they did not feel that they worked excessive hours.

The manager told us that there were no systems in place to calculate the numbers of staff required to cover the service. All staff were employed on a flexible contract to enable flexibility in the service. In addition we were told that there was an on-going recruitment process in place, to ensure they have enough staff to support the service. Senior care workers were employed with capacity to fit in when staff were on annual leave or sick leave. In addition four care workers were paid to be on call during the weekends to cover for emergencies. This indicated that the provider had a flexible staff team to support the changing demands of the service.

Assessing and monitoring the quality of service provision ✖ Action needed

The service should have quality checking systems to manage risks and assure the health, welfare and safety of people who receive care

Our judgement

The provider was not meeting this standard.

The provider did not have an effective system to regularly assess and monitor the quality of service that people received.

We have judged that this has a moderate impact on people who use the service, and have told the provider to take action. Please see the 'Action' section within this report.

Reasons for our judgement

The majority of the people that we spoke with were satisfied with the standard of service that they received. One person told us, "They are very good, I get on with all the carers." Another person said, "No concerns about the care at all, they have been very good with her." Some people told us that staff were sometimes late, but that they always had a visit.

There was a complaints procedure in place and we were told that people were given information about how to complain within the information packs placed in people's homes. People that we spoke with said they would call the office if they had any concerns. We saw that there was a system in place for recording and investigating complaints, but these were not analysed for trends. Therefore, the provider could not demonstrate that complaints were used to improve the service. In addition we found information on a staff member's records which indicated that a complaint may have been made against this member of staff, and the manager could not locate a record of the complaint. This indicated that not all complaints were being recorded and fully investigated.

We saw that there was a system in place for seeking people's views on the quality of the service. Information received from surveys were analysed, however, no action plan was in place to show how the provider would act on any short falls identified. A number of people told us they had never received a survey. One person said, "I have not had a telephone call or a questionnaire to check if I am happy."

We saw that there were systems in place to monitor the delivery of the service, such as auditing of time sheets, care records, spot checks etc. However, the manager didn't have an overview of when these audits had been completed, so we couldn't judge the frequency at which the systems were being monitored. One person told us, "I have never known the care records to be collected for checking and I have been using the service two years." In addition some people told us that their care was not been reviewed and that they never see the management. One person told us, "The manager never comes out to check." This showed that whilst there were systems in place for monitoring the service, they were not

consistent and the provider could not be assured that every one's care was being monitored.

We saw from records looked at that a member of staff had been suspended from duty for neglect, but no information about the disciplinary process or outcome was seen. The member of staff was at work at the time of our inspection. The manager said that he couldn't locate the records. This meant that the provider was unable to show that staff conduct was effectively investigated in this instance. We saw that this may have resulted in people being at risk of harm.

There was a management structure in place to enable the effective running of the service. However, the provider may wish to ensure that key staff working in the office are aware of, and can demonstrate the effectiveness of the systems. This is because at some point during the inspection the manager was not present, and senior staff could not give us information about how the service was monitored.

This section is primarily information for the provider

Action we have told the provider to take

Compliance actions

The table below shows the essential standards of quality and safety that **were not being met**. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010** **Care and welfare of people who use services**
	How the regulation was not being met: Care plans lacked details about people's needs. People's changing needs were not always reviewed to ensure staff were up to date. Care plans and risk assessments were not always available in a timely manner and staff were not always given information to enable them to care for people effectively. This is in line with regulation 9 (1) (a) (b)
Regulated activity	Regulation
Personal care	**Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2010** **Safeguarding people who use services from abuse**
	How the regulation was not being met: Staff's failure to follow the provider's procedures has resulted in people using the service being put at risk of harm. This is in line with regulation 11 (1) (a)
Regulated activity	Regulation
Personal care	**Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010** **Assessing and monitoring the quality of service provision**

This section is primarily information for the provider

	How the regulation was not being met: Complaints were not analysed so that they can be used to improve the service. Not all complaints were being recorded and fully investigated. Some people had not been asked about the quality of the service they received. Where people had been asked about the quality of the service the result had been analysed, but there was no action plan to show how the service would improve from shortfalls identified. Some people said their care had not been reviewed or monitored. An overview of when audits have been competed was not evident. Investigation into staff conduct was not managed effectively. This is in line with regulation 10 (1) (a) (b) (2) (b) (i) (ii)

This report is requested under regulation 10(3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider's report should be sent to us by 17 December 2013.

CQC should be informed when compliance actions are complete.

We will check to make sure that action has been taken to meet the standards and will report on our judgements.

About CQC inspections

We are the regulator of health and social care in England.

All providers of regulated health and social care services have a legal responsibility to make sure they are meeting essential standards of quality and safety. These are the standards everyone should be able to expect when they receive care.

The essential standards are described in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. We regulate against these standards, which we sometimes describe as "government standards".

We carry out unannounced inspections of all care homes, acute hospitals and domiciliary care services in England at least once a year to judge whether or not the essential standards are being met. We carry out inspections of other services less often. All of our inspections are unannounced unless there is a good reason to let the provider know we are coming.

There are 16 essential standards that relate most directly to the quality and safety of care and these are grouped into five key areas. When we inspect we could check all or part of any of the 16 standards at any time depending on the individual circumstances of the service. Because of this we often check different standards at different times.

When we inspect, we always visit and we do things like observe how people are cared for, and we talk to people who use the service, to their carers and to staff. We also review information we have gathered about the provider, check the service's records and check whether the right systems and processes are in place.

We focus on whether or not the provider is meeting the standards and we are guided by whether people are experiencing the outcomes they should be able to expect when the standards are being met. By outcomes we mean the impact care has on the health, safety and welfare of people who use the service, and the experience they have whilst receiving it.

Our inspectors judge if any action is required by the provider of the service to improve the standard of care being provided. Where providers are non-compliant with the regulations, we take enforcement action against them. If we require a service to take action, or if we take enforcement action, we re-inspect it before its next routine inspection was due. This could mean we re-inspect a service several times in one year. We also might decide to re-inspect a service if new concerns emerge about it before the next routine inspection.

In between inspections we continually monitor information we have about providers. The information comes from the public, the provider, other organisations, and from care workers.

You can tell us about your experience of this provider on our website.

How we define our judgements

The following pages show our findings and regulatory judgement for each essential standard or part of the standard that we inspected. Our judgements are based on the ongoing review and analysis of the information gathered by CQC about this provider and the evidence collected during this inspection.

We reach one of the following judgements for each essential standard inspected.

✓ **Met this standard**	This means that the standard was being met in that the provider was compliant with the regulation. If we find that standards were met, we take no regulatory action but we may make comments that may be useful to the provider and to the public about minor improvements that could be made.
✖ **Action needed**	This means that the standard was not being met in that the provider was non-compliant with the regulation. We may have set a compliance action requiring the provider to produce a report setting out how and by when changes will be made to make sure they comply with the standard. We monitor the implementation of action plans in these reports and, if necessary, take further action. We may have identified a breach of a regulation which is more serious, and we will make sure action is taken. We will report on this when it is complete.
✖ **Enforcement action taken**	If the breach of the regulation was more serious, or there have been several or continual breaches, we have a range of actions we take using the criminal and/or civil procedures in the Health and Social Care Act 2008 and relevant regulations. These enforcement powers include issuing a warning notice; restricting or suspending the services a provider can offer, or the number of people it can care for; issuing fines and formal cautions; in extreme cases, cancelling a provider or managers registration or prosecuting a manager or provider. These enforcement powers are set out in law and mean that we can take swift, targeted action where services are failing people.

How we define our judgements (continued)

Where we find non-compliance with a regulation (or part of a regulation), we state which part of the regulation has been breached. Only where there is non compliance with one or more of Regulations 9-24 of the Regulated Activity Regulations, will our report include a judgement about the level of impact on people who use the service (and others, if appropriate to the regulation). This could be a minor, moderate or major impact.

Minor impact - people who use the service experienced poor care that had an impact on their health, safety or welfare or there was a risk of this happening. The impact was not significant and the matter could be managed or resolved quickly.

Moderate impact - people who use the service experienced poor care that had a significant effect on their health, safety or welfare or there was a risk of this happening. The matter may need to be resolved quickly.

Major impact - people who use the service experienced poor care that had a serious current or long term impact on their health, safety and welfare, or there was a risk of this happening. The matter needs to be resolved quickly

We decide the most appropriate action to take to ensure that the necessary changes are made. We always follow up to check whether action has been taken to meet the standards.

Glossary of terms we use in this report

Essential standard

The essential standards of quality and safety are described in our *Guidance about compliance: Essential standards of quality and safety*. They consist of a significant number of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009. These regulations describe the essential standards of quality and safety that people who use health and adult social care services have a right to expect. A full list of the standards can be found within the *Guidance about compliance*. The 16 essential standards are:

Respecting and involving people who use services - Outcome 1 (Regulation 17)
Consent to care and treatment - Outcome 2 (Regulation 18)
Care and welfare of people who use services - Outcome 4 (Regulation 9)
Meeting Nutritional Needs - Outcome 5 (Regulation 14)
Cooperating with other providers - Outcome 6 (Regulation 24)
Safeguarding people who use services from abuse - Outcome 7 (Regulation 11)
Cleanliness and infection control - Outcome 8 (Regulation 12)
Management of medicines - Outcome 9 (Regulation 13)
Safety and suitability of premises - Outcome 10 (Regulation 15)
Safety, availability and suitability of equipment - Outcome 11 (Regulation 16)
Requirements relating to workers - Outcome 12 (Regulation 21)
Staffing - Outcome 13 (Regulation 22)
Supporting Staff - Outcome 14 (Regulation 23)
Assessing and monitoring the quality of service provision - Outcome 16 (Regulation 10)
Complaints - Outcome 17 (Regulation 19)
Records - Outcome 21 (Regulation 20)

Regulated activity

These are prescribed activities related to care and treatment that require registration with CQC. These are set out in legislation, and reflect the services provided.

Glossary of terms we use in this report (continued)

(Registered) Provider

There are several legal terms relating to the providers of services. These include registered person, service provider and registered manager. The term 'provider' means anyone with a legal responsibility for ensuring that the requirements of the law are carried out. On our website we often refer to providers as a 'service'.

Regulations

We regulate against the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 and the Care Quality Commission (Registration) Regulations 2009.

Responsive inspection

This is carried out at any time in relation to identified concerns.

Routine inspection

This is planned and could occur at any time. We sometimes describe this as a scheduled inspection.

Themed inspection

This is targeted to look at specific standards, sectors or types of care.

Contact us

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