First City Nursing Services Limited

# Charmes Care

## Inspection report

Office 17b, First Floor, Mill Court Business Centre
Furrlongs
Newport
Isle Of Wight
PO30 2AA

Tel: 01983530458
Website: www.charmes-care.co.uk/

Date of inspection visit:
02 March 2023

Date of publication:
14 June 2023

## Ratings

| | |
|---|---|
| Overall rating for this service | Requires Improvement |

| | |
|---|---|
| Is the service safe? | **Requires Improvement** |
| Is the service well-led? | **Requires Improvement** |

# Summary of findings

## Overall summary

About the service
Charmes Care is a domiciliary care agency which provides support and personal care to people living in their own home. Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided. At the time our inspection visit commenced, 35 people were receiving a regulated activity from the service. When we completed our inspection activity, due to planned changes to the service this had reduced to 29 people.

People's experience of using this service and what we found
People's care plans were up to date and contained person centred information. However, not all risk assessments for people contained sufficient information which would enable staff to understand how to mitigate the risk of harm. This placed people at risk of not receiving the appropriate care and treatment they required. We have made a recommendation about this in the report.

Staff had received training in safeguarding people, and they knew how to report any signs of abuse, or any accidents and incidents. However, we found safeguarding concerns were not always recognised by the management team or shared with CQC and the local authority as required.

Most people and relatives we spoke with, felt staff were kind and caring but were dissatisfied with the service they received. This was in relation to the time of day they received their visit, the length of the visit and communication with the management team.

Staff did not always feel supported in their role and felt they were not listened to if they raised concerns. Travel time was not always allocated and staff told us they were often rushed or unable to meet all of people's needs within the time given. This impacted on the culture of the service.

Staff had completed training in the safe administration of medicines and had their competency assessed to do so safely. People were happy with how they were supported around their medicines. However, improvements were needed to medicine records to ensure staff had the information they needed to administer 'as and when required medicines', and there was sufficient time in between doses.

There were quality assurance systems in place based on a range of audits. However, we found these were not always effective. They had not identified all the concerns we identified during this inspection.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

People told us care staff were kind and caring and they felt safe with them. Staff respected people's right to

privacy and dignity and promoted independence.

Staff felt they could contact the management team and they were informed of any important information or changes.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
The last rating for this service was requires improvement (published 26 July 2022). The service remains rated requires improvement. This service has been rated requires improvement for the last two consecutive inspections.

Why we inspected
This inspection was prompted by the previous rating of the service. As a result, we undertook a focused inspection to review the key questions of safe and well-led only.

For those key questions not inspected, we used the ratings awarded at the last inspection to calculate the overall rating. The overall rating for the service has remained requires improvement based on the findings of this inspection.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Charmes Care on our website at www.cqc.org.uk.

Enforcement
We have identified breaches of regulation in relation to, safeguarding, staffing and governance at this inspection. We have made a recommendation about risk management.

Please see the action we have told the provider to take at the end of this report.

Follow up
We will request an action plan from the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will continue to monitor information we receive about the service, which will help inform when we next inspect.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

**Requires Improvement**

The service was not always safe.

Details are in our safe findings below.

### Is the service well-led?

**Requires Improvement**

The service was not always well-led.

Details are in our well-led findings below.

# Charmes Care

**Detailed findings**

## Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Health and Social Care Act 2008.

Inspection team
The inspection was conducted by 1 inspector and 1 Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

Registered Manager
This provider is required to have a registered manager to oversee the delivery of regulated activities at this location. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Registered managers and providers are legally responsible for how the service is run, for the quality and safety of the care provided and compliance with regulations. At the time of our inspection there was a registered manager in post.

Notice of inspection
We gave the service 24 hours' notice of the inspection. This was because we needed to be sure that the provider or registered manager would be in the office to support the inspection.

Inspection activity started on 2 March 2023 and ended on 15 March 2023. We visited the location's office on 2 March 2023.

What we did before the inspection
We reviewed the information we had received about the service, including the previous inspection report

and notifications. Notifications are information about specific important events the service is legally required to send to us. We used the information the provider sent us in the provider information return (PIR). This is information providers are required to send us annually with key information about their service, what they do well, and improvements they plan to make. We used all this information to plan our inspection.

During the inspection
We spoke with the registered manager for Charmes Care, and 4 of the provider's senior management team. We spoke with the director of the service, who was also the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We also spoke to 3 external professionals who have had involvement with the service. We spoke to 6 staff members, 3 people who use the service and 8 relatives.

We reviewed a range of records, including 7 people's care records in detail, and 7 people's medicines records. Staff records were reviewed in relation to the care visits they completed. A variety of records relating to the management of the service, including audits, policies and procedures were also reviewed.

Requires Improvement

# Is the service safe?

## Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Systems and processes to safeguard people from the risk of abuse

- The provider's system to safeguard people had not always been effective. Allegations of harm or abuse were not always shared with the local authority or CQC as required. For example, we found 4 occasions where CQC had not been notified of safeguarding concerns, 3 of which had also not been shared with the local authority safeguarding team. This is important as the local authority have the legal responsibility to review the concerns, investigate and to ensure action is taken where required. CQC informed the local authority of these safeguarding concerns. We discussed this with the provider and the senior management team. They told us they would review their processes to ensure this does not happen again and referred these safeguarding concerns to the local authority retrospectively.
- The provider had a 'safeguarding adults' policy in place. However, this policy had not been followed by the registered manager or provider when the above concerns were raised. The provider's senior management team told us they had investigated one of these concerns at the time, but recognised they failed to identify it as a safeguarding concern. This meant people continued to be at risk of harm.
- Staff had received training in safeguarding and told us they knew how to report abuse. Although some staff had raised concerns with the management team, they had not recognised their duty to report concerns to the local authority or CQC if they felt people continued to be at risk.

The failure to protect people from abuse and improper treatment and a failure to have effective systems and processes in place to prevent abuse of people was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- The provider and senior management team told us they would robustly review their processes and staff knowledge to make the required improvements.
- However, people told us they felt safe and thought individual care staff were kind and supportive. One person said, "The carers [staff] are lovely; they are well trained and very respectful". Another said, "Yes, I do feel safe."

Staffing and recruitment

- Following our last inspection in 2022, the provider and senior management team had agreed to review staff travel times to improve the quality of care provided. At this inspection, we continued to find staff did not have sufficient time allocated to safely meet people's needs and provide person centred care.
- All staff we spoke to except for 1, raised concerns about travel time between care visits to people. Staff comments included, "We do not have enough time and always run late. We do what people need, but then we rush as we have to be at the next client's [person] visit", "We have to be at a call the same time one

finishes. This then makes us run behind" and "I had some time off and when I went back, one of my regular clients had not had a shower for over a week, as the staff covering did not have time to do it."
● The registered manager told us staff were not allocated travel time if they were visiting people who all lived within one geographical area. We reviewed 6 staff rotas who were supporting people within one town. We found the amount of time it would take staff to travel between people's care visits, was not accounted for. For example, one staff member visited 9 people over the course of their shift, where no travel time was allocated. The average travel time accumulated was 58 minutes. This meant staff were either unable to stay the full length of time allocated to people or had to work over their paid hours to meet people's needs safely.
● People and relatives told us, although staff were kind and caring, they were frequently late or did not stay the amount of allocated time for care visits. Comments included, "I expect them [staff] in the morning not lunchtime, but they are regularly late. They are supposed to be here for an hour, but I never get an hour", "They [staff] can be up to an hour and a half late sometimes" and "Carers [staff] they are not always on time."

The failure to ensure there were sufficient staff deployed to meet the needs of people's personal care and treatment is a breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014.

● The provider and senior management team told us, recruitment of staff in the local area had recently been particularly challenging. This had resulted in ongoing recruitment drives and incentives being offered to new and existing staff to improve staffing levels. The provider assured us, they would continue to look at ways to improve staffing levels, travel time and the quality of care provided.
● Safe and effective recruitment practices were followed.

Assessing risk, safety monitoring and management
● People's care plans did not always contain enough information for staff to understand how to mitigate risks. Although some risks were clearly identified with guidance for staff, other identified risks lacked sufficient detail.
● One person's care plan described they had a heart condition. There was no information about what this was, or how they may present if unwell. This is important so staff would recognise when to take action. Another person had an allergy to some food types. Their care plan did not contain sufficient detail to support staff to recognise early warning signs and what to do. A third person had behaviours that could be a risk to others, although there was some guidance for staff about what to do, the person's care plan did not describe the behaviours, so staff would understand when to follow the guidance. This meant people were at risk of staff not understanding how to safely mitigate these known risks.
● We discussed these concerns with the provider and their senior management team, who took immediate action to update people's care plans with the required information. However, we had identified risk assessments needed further information at our last inspection.
● Risk assessments had been completed of people's homes and living environment to promote the safety of both people and staff.
● There were lone working arrangements in place to promote staff safety

We recommend the provider review their processes to ensure all risks are clearly identified with sufficient information to enable staff to safely meet people's needs.

Using medicines safely
● Medicines were not always administered safely. Where people were prescribed 'as and when required'

[PRN] medicines to be taken up to 4 times a day, there was not always a 4-hour gap in between staff administering them. Although the gaps between administration were between 3 hours and 3.5 hours, repeated occurrences of less than a 4-hour gap have the potential to cause harm and were not in line with the prescriber's instructions.

● Where people received PRN medicines, there was not always sufficient information to guide staff when to give them. For example, one person was prescribed medicine for constipation, there was no person-centred description when these should be offered, such as the normal bowel pattern for the person, so staff would understand when to offer this medicine. Another person was prescribed a medicine to be given 'as and when required' (PRN) for a heart condition. The person's care plan did not sufficiently describe how they may present, so staff would understand when to administer this medicine to prevent an emergency. Staff we spoke with were not able to describe how the person may present if they needed this medicine. One staff said, "I'm not sure, I would just ring 999." This placed the person at risk of harm.

● Medicines audits were carried out. However, they did not pick up on the concerns we found during the inspection.

● We discussed these concerns with the provider and their senior management team, who took immediate action to update people's medicines records with the required information.

● People were supported to be as independent with their own medicines where possible. Electronic medicines administration records (MAR) were completed, and topical cream records (T-MAR) were used to record when staff administered these medicines to people.

Learning lessons when things go wrong

● Accidents and incidents were recorded and monitored by the registered manager. The provider and senior management team had oversight of these, and any themes or patterns were analysed and discussed. However, they had failed to identify where some incidents or concerns raised, were safeguarding and further action was required to ensure people were safe.

● Lessons learned were shared between all services run by the provider. This helped ensure actions would be taken to improve the service and reduce the risk of similar incidents occurring to all people.

Preventing and controlling infection

● Staff had access to personal protective equipment (PPE), such as aprons, masks and gloves to help reduce cross infection risks.

● People confirmed staff wore appropriate PPE as required.

● We were assured that the provider's infection prevention and control policy was up to date.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the Mental Capacity Act (MCA). In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS)

● We found the service was working within the principles of the MCA.

Requires Improvement

# Is the service well-led?

## Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection we rated this key question requires improvement. At this inspection the rating has remained requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- Governance systems were not always effective. Audits being completed had not identified the concerns we found during our inspection.
- Systems and processes in place failed to identify where safeguarding concerns should have been shared with external professionals. In addition, information within people's care plans and medicine records did not always have sufficient detail to mitigate risks. We have reported more about this in the safe domain of this report.
- The electronic care system allowed the management team to monitor care calls to people. However, there was no overall auditing process to be able to identify if staff arrived on time, stayed for the time allocated or to robustly identify any regular missed visits. This is important to ensure any themes or trends are identified and action taken if required.
- There were policies and procedures in place to aid the running of the service. For example, there were policies on safeguarding, whistleblowing, and training. However, these policies had been ineffective at ensuring when concerns were raised, action was consistently taken. The provider and senior management team took immediate action following our feedback, to support staff and review the processes for them to raise concerns.

The failure to have effective systems in place to assess, monitor and improve the quality and safety of the service placed people at risk of harm. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people; Engaging and involving people using the service, the public and staff, fully considering their equality characteristics

- We received mixed feedback about, the timings of care visits and a lack communication with people from the management team. One person said, "The carers [staff] I don't have a problem with; the organisation is chaos. We have no communication whatsoever." Another told us, "Staff try their best but do not always have the time to do all the things I need them to." We discussed the feedback we received with the provider and senior management team, who told us they would speak to people and look at how they could improve

engagement.
● Relatives told us they felt when they raised concerns, they were not always confident action would be taken. They felt information was not shared with them consistently and they did not receive feedback to concerns they raised. Comments included, "I have called [the office] several times, but nothing gets done", "If I ring [the office] and complain it doesn't go anywhere" and "They [management team] are feeding us, and their own staff, fairy tales. If they called and explained, I wouldn't mind so much, but they don't." We discussed this with the provider and senior management team, who took immediate action to review their processes so they could improve communication and feedback.
● Staff were very negative about some aspects of their work and did not feel their concerns were listened to or acted upon. Although most staff told us they felt the registered manager was supportive, they felt they were put under extreme pressure to work additional hours, and nothing changed when they raised concerns. We discussed this with the senior management team who told us they were arranging to meet with staff to look at ways they could improve their oversight and support.

The failure to seek and act on feedback from people, relatives, and staff to continually evaluate and improve the service, was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

● People told us they felt their regular staff knew them well and provided good care. Comments included, "The carers [staff] themselves are extremely dedicated" and "They [staff] have always been respectful and professional and have always done what I wanted". A relative said, "They [staff] are doing their best under difficult circumstances".
● Staff were clear about their roles and told us they were kept up to date with information about people or changes from the management team.
● Protected characteristics, including sexuality, religion, race and disability, were identified within people's care plans, respected and supported.
● Feedback was gathered from people using the service and their relatives using quality assurance surveys and one to one conversations. However, these methods had been ineffective at ensuring action was consistently taken to address concerns raised.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The provider had a duty of candour policy that required staff to act in an open and transparent way when accidents occurred. We saw records that demonstrated apologies were sent to people when it had been identified there was an error. However, some people and relatives told us they did not feel this happened consistently.
● The registered manager and provider were aware of their responsibilities regarding duty of candour.

Continuous learning and improving care; Working in partnership with others
● The registered manager told us they worked in partnership with other services, and health and social care professionals such as the local authorities, social workers, district nurses and GPs to deliver effective care.
●The provider and senior management team were engaged and open to the inspection process. They remained open and transparent throughout, and took immediate action where concerns were identified during this inspection.

This section is primarily information for the provider

# Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment<br><br>The registered persons failed to protect people from abuse and improper treatment and to have effective systems and processes in place to prevent abuse of people |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 17 HSCA RA Regulations 2014 Good governance<br><br>The registered persons failed to have effective systems in place to assess, monitor and improve the quality and safety of the service and to to seek and act on feedback from people, relatives, and staff to continually evaluate and improve the service. |

| Regulated activity | Regulation |
|---|---|
| Personal care | Regulation 18 HSCA RA Regulations 2014 Staffing<br><br>The registered persons failed to ensure there was sufficient numbers of staff deployed to meet people's needs  safely. |