Carewatch Care Services Limited

Carewatch (Norfolk)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

In April 2017 we inspected this service and found five continued breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014. The service was not employing enough staff to meet people's needs. Risks to people's safety were not sufficiently assessed or managed and people's care had not been planned or delivered to meet their individual preferences. There was poor oversight of complaints and the provider's governance systems were ineffective. Following the inspection, we sent the provider a warning notice telling them that they must have adequate governance processes in place by 30 June 2017. The provider requested an extension to this deadline to 30 August 2017.

We inspected the service again on 13 and 15 December 2017. We identified the same breaches of regulation as the previous inspection. These were breaches for staffing levels, safe care and treatment, person centred planning, management of complaints and good governance. We rated the service as requires improvement overall, inadequate in well- led and placed the service in special measures. We do this when services have been rated as Inadequate in any key question over two consecutive comprehensive inspections. The Inadequate rating does not need to be in the same question at each of these inspections for us to place services in special measures.

Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, it will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

This service is a domiciliary care agency. It provides personal care to people living in their own homes. At the time of the inspection it was providing care to 260 people. The service provides both 15-minute welfare checks or calls to support with medication administration only. Longer calls were scheduled according to people's assessed needs. The service also supported people over a limited amount of time to prevent

hospital admission or readmission to hospital.

There was a registered manager at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are registered persons. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

During the first day of our inspection on 9 August 2018 we identified four continued breaches of regulation. We have rated this service as requires improvement in four key questions and inadequate in well- led. This means the service will stay in special measures.

Improvements had been made but were not firmly embedded across the whole service which meant people received different outcomes of care. Some recent changes within the service compromised the continuity of care. For example, office staff, including coordinators. The registered manager said to make improvements to the service some of the staff employed had needed to leave to develop a new and more positive care culture. However, changes in the staff team meant that not all the care visits were planned sufficiently ahead or around the needs and wishes of people using the service. Staff said they did not always have regular care visits or adequate travel time. This meant they did not always arrive on time for the care visit, or stay the correct amount of time. This evidence supported a repeated breach of regulation 18: staffing.

Recruitment of new staff was not always carried out in line with the organisation's policies and procedures which meant people were not fully protected against the potential employment of unsuitable staff.

There were processes in place to help ensure people received their medicines as intended but audits were not always completed in a timely way and we found improvements were required in recording. This supports a breach of regulation 12: Safe care and treatment.

Risk assessments regarding people's care were documented. However, the individuals' care plans and records were not always adequate in informing actions staff should take to keep the person safe.

Infection control measures were in place but not all staff were adhering to them placing people at an increased risk of cross- infection. We found through discussion with people that not all staff were wearing personal, protective clothing.

Safeguarding people from abuse was effective because the service provided staff with adequate training and had systems in place for dealing with any allegation of abuse. The agency worked closely with the local authority to ensure all allegations were reviewed.

The service had systems in place to review all accidents and incidents within the service. This enabled the service to evaluate what had gone well or what they could learn to help ensure that the risk was reduced in the future.

The service kept up to date with changes to legislation and best practice but this was not always communicated to care staff. Several staff said they had not had recent face to face supervision, or direct observation of their practice which they felt was due to recent changes to the management team. We were unable to see from the information provided that all supervision was up to date in line with the organisations policy. This meant some staff were working in line with their own values and not necessarily the values of the company. Communication was disjointed across the different teams. This supported a breach of Regulation 18: staffing.

Staff received regular training and the quality of training provided through induction was said to be good. However, some staff said they did not have the time to attend specific training around the needs of people using the service.

People mostly had their health care needs met and this was reflected by what staff told us. However, we were concerned that staff were rushing in and out of people's houses which increased the risk of them missing something important or not noticing a change in the person's needs. We considered this in line with poor record keeping which could increase the risk of the person receiving poor care.

Staff had received training in the Mental Capacity Act 2005 (MCA.) The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. Care plans recorded people consent, (or their legal representatives consent) to care and treatment.

We saw examples of where people's choice was diminished in relation to their choice of carer and their preferred timing of care call. People also stated they were rushed or their call was cut short which affected the person's experience of their care.

People were consulted about their care plan and this was reviewed although people felt contact with the office was not always regular. Care plans were not sufficiently robust or person centred. Records were not always up to date, or legible.

People knew how to complain and staff understood the process and how they should support people if they had concerns. The paper records reviewed showed the outcome of complaints received were not always fully documented to show if it had been upheld or how it had been resolved. However, complaints were also logged electronically and could not be closed until all necessary actions had been taken. This was not viewed as part of the inspection and would have provided a fuller audit trail.

The service was not sufficiently well managed. There were insufficient resources to ensure people always received good outcomes of care and received support around their needs. Quality audits did not always demonstrate how the service was identifying and making necessary improvements in a timely way.

The service remains non -compliant in a number of areas and will therefore remain in special measures due to its history until we are confident that the service can make and sustain the necessary improvements. This supported a breach of regulation 17: Good Governance.

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.

The deployment of staff was not yet effective. People did not always get their needs met in a timely way.

Staff recruitment was not always completed in line with the company's policy so we were not assured it was sufficiently robust.

Staff were trained to administer medicines and there were systems in place to help ensure people received their medicines as intended. Medicine audits were not sufficiently robust and did not always identify errors so we could not be assured people always had their medicines safely.

People's care plans and risks assessments did not always give enough information about how to deliver the persons care safely. Lessons were learnt following incidents or events affecting the well -being and safety of people using the service.

People were safeguarded from abuse as far as possible and staff had a good understanding of how to safeguard people in their care.

Infection control measures were in place to stop the spread of infection but not all staff were following the policies.

Is the service effective?

Requires Improvement

The service was not effective.

Not all staff felt well supported and records did not clearly show all staff had received up to date supervision. Training provided in the initial induction was highly regarded but not all staff felt they had the time to uptake additional training.

The agency considered current legislation and guidance in the way it planned and delivered care.

Staff supported people with their care needs and treatment and did so with people's consent. Staff had a reasonable

understanding of the mental capacity act and referred to other services where people needed support with decision making.

Staff supported people to stay healthy and referred people to other health care professionals as required.

Is the service caring?

Requires Improvement

The service was not always caring.

The delivery of care was poorly planned. This resulted in some carers rushing and cutting care calls short. This had a negative impact on people and meant they did not always receive their care as intended.

Most of care provided promoted people's independence and dignity but this was not always the case particularly when people were rushed.

The agency consulted with people about the service they were receiving and their plan of care. The service reflected in their literature how feedback had been acted upon.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Records in some instances were poor which had the potential to affect the care being delivered when provided by a carer unfamiliar with the person's needs.

Not all care plans were up to date or adequately reflected people's current needs.

The service had an established complaints procedure and outcomes were recorded following a complaint.

Is the service well-led?

Inadequate

The service was not well- led.

There have been repeated breaches of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 and the service has not yet demonstrated that they can sustain improvements across the service.

We found a different level of experience for people across the service with some reporting poorly organised and late running care visits which led us to conclude the deployment of staff was

in-sufficient The agencies own quality assurance systems were ineffective at identifying areas of concern or sufficiently addressing these in a timely way. The service continued to fail to deliver high quality care	

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Prior to this inspection we reviewed the information we already held about the service. This included the previous inspection reports. We reviewed notifications which are important events the service is required to tell us about. We also viewed complaints and share your experience which are on the CQC website and enables people to fill in their experiences of the service anonymously or otherwise. We also received an action plan following the last inspection.

We reviewed the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection team consisted of two inspectors, an assistant inspector and an 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. The experts by experience contacted people and relatives for feedback via the telephone over two days.

The first day of the inspection was 9 August 2018 and was announced.

We carried out some telephone calls on the 10 and 13 August to people using the service, relatives, health care professionals and staff. We visited some people using the service on the 14 August and again on the 16 August. We also carried out a second site visit on 16 August to gather more information. We then arranged with the registered manager to come back and provide some feedback when we had the opportunity to collate the information we had gathered. This took place on 7 September 2018.

As part of the inspection we visited six people in their own homes and spoke with a further 20 people on the telephone. We spoke with three care staff whilst doing our site visit, as well as four office senior staff. We

spoke with a further seven staff on the telephone. We spoke with the registered manager who was the area manager but registered for this service to give it some stability. We also met the branch manager who is in the process of registering with the Care Quality Commission as the registered manager. We met the Quality Service Improvement Manager. We asked both for a break-down of their role and what they had been working on since our last visit. We spoke with four relatives and six health care professionals including the local authority who commission the service.

As part of the site visit we looked at records of staff recruitment and supervision for seven members of staff. We requested and received the staff training matrix. We looked at the assessments and care plans for nine people. We also looked at daily notes and medication administration records and the auditing of these. We looked at financial audits for two people. We looked at the service users' guide, the complaints policy and records of complaints made with the action taken to investigate them. We looked at a small sample of records associated with people's views about the quality of the service. We requested information be sent to us before and after the site visit.

Requires Improvement

Is the service safe?

Our findings

At the last inspection to this service on 13 and 15 December 2017 we rated this service as requires improvement in this key question. There were repeated breaches of regulation 18: staffing and regulation 12: Safe care and treatment. We found there were not enough staff to meet people's assessed needs and care and treatment was not always provided safely.

At our inspection on 9 August 2018 we found a continued breach of regulation 18. There had been some improvement in terms of people receiving safe care and treatment but this was undermined by the fact at times there were insufficient staff to provide the care people required. This was a repeated breach of regulation 12.

People did not always receive a safe, reliable service provided by someone who was familiar with their needs and stayed the allocated amount of time. Although most people spoken with valued and trusted their regular, allocated carers they said when they were off duty and at the weekend the service was unreliable. Staffing rotas showed less staff available to work at weekends and for staff working they did longer hours. People told us they did not always know who would be delivering their care or at what time.

Variations in call times affected people's overall confidence in the service. One person referred to feeling like they were 'imprisoned' and went on to explain that they believed if the call was missed the carer did not get paid so they felt obligated to stay in and wait for them although they were never quite sure when they might arrive. The registered manager confirmed that carers would get paid. Another person said in relation to their evening call, "It could be half four or five up to six pm." One person told us their relatives care call was two hours late the weekend of our inspection and said their neighbour who was living with dementia did not get a call until lunch time. We asked would you recommend the agency they said 'no' but would recommend the carers.

We had confirmation from carers that the weekend following our inspection was hectic and calls ran late including for the person who called us to complain. People told us variations of call times depended on which staff were allocated stating some staff 'did not like to start too early. One person said, "I have a regular carer and am satisfied but in recent weeks when my care call is covered by other carers then I can't be sure when I will get my call." They reported wide variations of call-times. They said this had lead them to cancel a couple of calls because they would be provided too late to meet their needs.

People did not always receive the care that had been agreed as part of their assessment of need because there was inadequate planning of calls with insufficient travel time. A letter in staff files following CQC's last inspection stated that calls had been, 'rescheduled to allow five minutes travel time.' The letter further stated, 'It was imperative that staff remain in the call for the allocated time unless a service user asked them to leave. Carers must record this and explain the reason why.' The registered manager told us that they had revised the duty rosters for staff so that travelling time was better accounted for and staff would not need to cut visits short to avoid being very late for their next visit. Travel time was accumulated with five minute travel time between calls close together and 15 minutes for calls further apart both of which were

insufficient according to staff we spoke with.

People reported calls being cut and at times being rushed because of the knock-on effect of carers running late throughout the day. One person told us, "The carers can't do their jobs properly, i.e. I find water on the floor, my trolley is not positioned properly so I find it difficult to get about, I can make myself a drink and a sandwich but I can't fill the kettle. The bed is not made properly and I can only lay on my side so it can be uncomfortable. They said they got tired and needed to rest in the afternoon which was compromised if calls ran late." Another person told us 15-minute calls could be cut by half and explained how carers spent time logging in and out and writing care notes. This meant the amount of direct contact time with them was significantly reduced.

A carer told us, "My round is always full, I finish a call with one client and have to be at my next client at the same time but it's a 15 to 20-minute drive…Calls are cut often." They explained when they were delayed due to any given emergency with a client, they called the office to let them know. Another carer told us they had a fixed round during the day but not the evening. They said there was insufficient travel time and were always late. Their rotas showed calls scheduled back to back despite some being in different areas. Staff reported, 'constantly watching the clock.' This meant people did not always receive their allocated time at the agreed time.

Staff said weekend cover was more difficult as less staff were scheduled to work and most care calls were at peak times of the day putting extra demands on staff. Staff said at weekends they could work long hours with limited opportunity to take a break or sufficient time off between shifts. The registered manager told us that there were no scheduled calls between two pm and four pm so staff could take breaks which were scheduled throughout the day. Staff told us however additional calls could be added to their rotas which limited their opportunity to take their scheduled breaks. Staff told us there was insufficient management cover. There was however an on-call system carried by a senior and other senior staff including the registered manager were available to work. There were financial incentives to encourage carers to pick up extra work which had the potential to affect their safety and well- being when working long hours. Some staff reported working long hours affected their ability to attend meetings, supervision and training because they were unwilling to give up their time off or these were scheduled after their morning calls when they were too tired. However, the organisation monitored hours staff worked to ensure it did not impact on their ability to provide a good service.

The service was neither sufficiently planned or adequately coordinated so people would know who was delivering their care and at what time. People who used the service said their rotas were often not received, or received late. They said they often had to ring the office to find out who was coming. One person said, "We have not got a list of who is doing the evening calls. I don't know who is calling or when. The rotas are not reliable." This created anxiety and uncertainty for people.

People told us when they required two staff to assist they would often travel separately. One person said, "Their time keeping is not brilliant. With two staff we need to wait for both. The calls are not always well aligned from the previous calls and the next call." Another person told us the carer had started providing their care without waiting for the other carer to arrive although their care plan stated they needed two staff to help them. Staff confirmed how difficult it was to arrive on time for calls which impacted on people's experience of care and had an impact for the next visit.

The complaints log for June 2018 showed four complaints all related to the timing of calls and one also referred to staff not staying for the expected time. In one of these, the person was supposed to receive a staff call at 5.30pm but by almost 8.30pm, they had received no support. This did not put the person at any

immediate risk as their call was not related to providing personal care or medication support. The persons relative provide the support the person required but found their family member distressed because of what had happened.

There were 21 logged missed calls since January 2018. The registered manager said they had attributed these to problems to rostering rather than insufficient staff. Welfare checks were carried out to ensure the missed visit had not resulted in harm but this was not clearly documented or analysed by the service.

The above evidence supports a repeated breach of staffing, Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The recruitment process was still not sufficiently robust despite shortfall being referred to in the last inspection report. Staff records did not demonstrate that all new staff were of good character and had the right credentials for their job role. This compromised how the agency protected people from the employment of unsuitable staff who may not be appropriate to work in care. For example, gaps in employment history on the persons application form had not been explored as part of the interview process. We were unable to verify from records that all staff had a valid DBS check record and, or adequate references in place before commencement of their employment. For example, one staff record contained a letter showing that they were to complete classroom training on 31 January 2018, 1 and 2 February and 5 and 6 February with opportunities to observe care between those dates. However, their enhanced background check with the Disclosure and Barring Service (DBS) was not completed until 6 February, and their references were not obtained until 17 and 18 February 2018. For another member of staff starting in November their references were not received until 24 and 25 February 2018.

The provider's policy was clear about the importance of ensuring DBS disclosures were held securely, to protect confidential information about staff backgrounds. This stated that the DBS copy would be held securely, but the disclosure number and date obtained would be entered in their personnel file. This would help to confirm completion of the disclosure before staff started work. We found that the checklist was not being used robustly and, for three of the seven records checked, the information was missing. The checklists did not consistently record start dates for staff, or the dates references were received as an additional management check the information was complete and obtained in a timely way. The way in which the agency kept staff information had recently changed in line with changes to the Data Protection Act. Information relating to DBS checks was now kept separately and some information in staff personal files had not been removed in line with changes to data protection. Staff checklists were not completed in full to show robust recruitment.

At our last inspection to this service we identified concerns around the auditing of medicines which meant we could not be assured errors were identified or people always received their medicines as intended. Immediately following our inspection, the registered manager introduced a system to ensure everyone's medicine administration records (MAR) were reviewed regularly and there was oversight of these audits.

At our inspection on 9 August 2018 we looked at medication audits and staff training and competencies. We found medication audits were not always completed in a timely way and did not provide sufficient evidence that people had their medicines as prescribed. We reviewed a number of medicine records and found some concerns. For example, we saw codes being used on the medication record with no explanation as to what the code meant. Nothing was recorded on the back of the medication record or persons notes to explain why something had not been signed for. For example, we saw omissions for a person prescribed antibiotic medicines, staff had recorded a F for the lunch time dose. No care visits were scheduled for lunch time so we could only assume the person did not get their medicines at the times prescribed. In some instances, staff

had recorded an 'O' which they told us meant not given. There were no reasons given as to why a medicine had not been administered, although there was a prompt on the medication record stating staff should record why medicines had not been administered. Some medicines appearing on the medication had not been given at all which would suggest they had been discontinued but this had not been identified as part of the audit. If they had been discontinued they should be removed or crossed out to avoid confusion.

We found one person's medication chart starting 28 April 2018 was caught up within their care plan records and without a corresponding audit. We found errors within this chart that did not support staff always followed safe procedures for administering and then signing them. We noted that there were no signatures for their morning medicines on 16 or 17 May, although their daily records showed visits were completed at that time and did say that the person was given their medicines. There were also omissions for evening medicines for the same person, on 15 and 16 May. On neither of those two visits, did the daily notes contain references to staff having administered medicines.

We had concerns for the same person. They administered their own insulin and there was a clear plan for them to do so and they had been assessed as competent to do so. Their care plan stated staff were to check that they took the right amount of insulin both morning and evening. However, the dose of insulin the person was taking as agreed by the GP and recorded in the persons daily notes differed from the dose the care plan stated. This presented a risk that staff would not be aware of the correct dosage when they were observing that the person had taken the right amount.

People's medication records included a list of medicines people had been prescribed and an assessment documenting people's consent and level of support they required in taking their medicines. There was no additional information such as how the person took their medicines and how they should be stored. We had to ask what the arrangements were for collecting and returning medicines as this was not always recorded in their care plan. There was no separate guidance to help staff understand what medicines they were administering or potential side effects. The registered manager said medicines came with information leaflets and prescribing instructions which helped staff know what they were administering and when it was appropriate to do so. However, we did not see any separately written protocols to help staff know when a person might need their medicine.
We identified one person who required medicines on an empty stomach 30 minutes before food but because times were not recorded it was hard to see if this happened in practice. We saw there was a sheet of sample staff signatures so it was possible to see who had administered the medicines.

Audits on MAR sheets were completed to ensure medicines were given as intended. Where errors were identified, which usually related to missed signatures the audit officer we spoke with said this was either recorded as part of the audit or within staff notes on the computer. They showed us their auditing schedule and said they had 100 % compliance with all MAR records being audited each month for the preceding month. However, when we looked at records we found MAR sheets dated March to April had not been audited until July. Some MAR sheets included dates but did not have the month or year making the auditing process retrospectively very difficult. Delays in auditing records also made it very difficult to address errors in a timely way or to identify where people might be at risk.

Professionals commented favourably about the agency but said there were some issues about communication. Pharmacy staff said there were some very good members of staff who were pro- active in their care for people but said there had been problems with over- ordering of medicines without first checking if these were needed. This resulted in stock piling of medicines which only became apparent when people passed away. This could increase the risk of the person taking the wrong medication or an increased risk of overdosing.

Staff confirmed they received training in medication as part of their induction and there were spot checks on their delivery of care which always included medicine administration. However, one staff member said they had not had any updated training for at least eighteen months. Training statistics showed some training gaps.

This was a continued breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People did not always receive care based around their assessed needs. The service was poorly planned at times and staff did not always stay for the correct amount of time. The care documentation in people's care records did not always adequately describe actions to be taken by staff or show how guidance was incorporated into their risk assessment or plan of care. This did not assure us that care was always delivered safely.

Nearly everyone we spoke with expressed their confidence in their regular carers but said they were anxious when being supported by someone less familiar with their needs. We received several negative comments in relation to safe moving and handling practices. One person said carers sometimes started providing care without waiting for the second member of staff thus compromising their safety. Another person told us they were generally confident with staff when being supported to mobilise but said staff sometimes rushed making them feel uneasy. Staff spoken with confirmed calls requiring two carers were sometimes poorly coordinated. This was feedback to the registered manager who had been out delivering care the weekend following the inspection and had identified some issues regarding double assist calls and told us these would be addressed.

Although risks were documented in people's care plans there was a lack of specific or contradictory information to help care staff deliver care safely. For example, one person's moving and handling risk assessment indicated there was a low risk and they could be assisted by one member of staff. However, their care plan, stated they needed two staff to deliver their care. Their individual agreement with the local authority also specified two staff were needed at the person's visits. We could therefore not see if this person's needs were accurately reflected by the documentation.

In other records we found variable level of detail about how staff should fix people's slings to their hoists to move them both comfortably and safely. For example, despite having specific information from a health professional, their guidance about supporting a person safely and comfortably was not incorporated into the care plan for staff to follow. The registered manager said this was because up until recently occupational therapists had been sending their method statements and risk assessments directly to service users and not to the care provider. This has since been rectified. Another care plan we reviewed, did contain more detailed information about fixing the sling. However, this overlooked prompts for staff about checking the person's catheter bag and tube to ensure their comfort and safety when they assisted the person to move.

There was guidance for staff about visual checks they should make to ensure equipment such as hoists, was safe when they used them. The guidance also stated that people's equipment should be maintained and serviced properly, every six months. It was the responsibility of the person using the equipment to ensure it was serviced but the expectation was that carers should raise any issues. Staff were not always recording dates of when they had checked the equipment to ensure it was safe for people to use. We saw an incident in which a pendent alarm failed when a person needed it following a fall. This highlights the importance of regular, recorded equipment checks. The registered manager stated that the servicing of equipment was via the council and carers checked the equipment for in date certification and obvious problems before using. Care plans also included the date of last service and updated as part of the service user review.

Risk assessments in people's homes considered individual risks and potential risks from the environment. There was guidance about promoting people's safety with their mobility and the equipment staff needed to use to support people safely. We saw risk assessments associated with lone working, trip hazards, fire hazards and whether people had pets that might present a risk to staff. The manager had recently emphasised to staff, the importance of recording that they always ensured people had any assistive technology, such as call pendants, to hand and within reach. This was following an incident where a person had fallen and had not had their call pendant to hand. We found information about this in a newsletter to staff compiled in July 2018 to help ensure lessons were learnt.

There were systems in place to help ensure people were protected as far as reasonably possible from abuse. Staff received training to help them recognise types of abuse and actions to take should they suspect potential or actual abuse.

Staff files showed that staff completed training in safeguarding people from abuse, as part of their induction. The agency's "Service User Guide" produced for people who used the service, also listed this as part of the minimum training people could expect staff to complete and to update regularly.

We noted that the service user guide outlined for people, what sorts of things could constitute abuse. This contributed to providing information to people about their safety and protection.
The staff newsletter from July 2018, showed that the management team had emailed copies of the provider's procedures for protecting people from abuse to staff. This stated that staff must read the information and confirm they understood it to show they were fully aware of their responsibilities.

We spoke with several staff who could tell us what might constitute abuse and what actions they might take including reporting concerns both internally and if they felt actions were not taken adequately to protect people they would also report to external agencies.

We spoke to the local authority who commission the service and Care watch was one of the preferred providers. They told us the number of concerns and complaints and safeguarding concerns have dropped considerably from a year ago, and were less than for many providers of a similar size. The provider sent us the PIR earlier this year which showed a significant reduction in reported safeguarding concerns.

They said the registered manager has been very open and transparent when they raised issues, and said they have always conducted a thorough investigation and reported back to the local authority on the outcome. Similarly, they said they flagged up any concerns with individuals they support and did so in a timely manner with social services so appropriate actions could be taken. The local authority said if a call was missed this would be reported to them and reasons for missed calls, investigated. Actions would be put in place to prevent a reoccurrence to ensure the safety of people.

The agency had developed a lesson learnt folder which looked at incidents and events across the service. As part of the review the registered or branch manager would analysis events or specific incident to see if any actions could have been put in place to prevent the occurrence or any lessons learnt to prevent an occurrence.

Measures to prevent the spread and control of infection were in place and staff received training to help them understand the important of infection control. However, some staff practices put people at increased risk of infection. Staff records showed that their initial induction included training in the prevention and control of infection. Staff confirmed that personal protective equipment was supplied by the office but two staff said this was not always provided in a timely way.

People consistently told us that staff wore uniforms but did not wear aprons. One person told us, "At our review we haven't raised the apron issue. No, they didn't ask. They do get warm in their outfits that's why they don't wear the apron. Not surprising because they have to rush about." One person told us administrative staff providing care did not wear gloves because of 'their nails.' This meant staff were not acting in accordance with best practice.

Requires Improvement

Is the service effective?

Our findings

At the last inspection on 13 and 15 December 2017 this service was rated requires improvement in this key question. People were confident in their regular carers but said their choices and preferences were not always upheld and people were not confident that all carers had the right level of training to meet their needs. At our most recent inspection on 9 August 2018 we found similar issues.

Staff received adequate training and induction but not enough support to help them develop their confidence and further their professional development. People raised concerns that staff did not always use their initiative or deliver good care.

People's feedback was mixed. Some felt carers who knew them well did a good job but others expressed concerns about the level of experience and training some of the newer carers had. They raised concern about having to tell new carers about everything rather than them using their initiative or reading the care plan first.

Some staff felt poorly supported and not kept up to date with changes in the organisation, the delivery of care or best practice in line with operational guidance.

The service had developed a number of key roles within the branch including staff champions who had a specific area of interest or expertise. Champions could support other staff by offering advice or taking a lead in a specific area of practice. We spoke with one member of staff who had experience in their lead role but could not tell us how the organisation supported them or how they had been able to put their lead role into practice. This was a missed opportunity by the agency to support staff with their professional development.

One member of staff told us after a number of attempts to get on to an enhanced care course they heard nothing and gave up. They said details of training were sent out but when staff expressed an interest they got no response. Another member of staff said. I have been asking for palliative care training for years but this has not been provided." The registered manager had completed a provider information return but had not given details of staff holding additional qualifications. We asked them for this information retrospectively but it had not been provided at the time of writing the report. The registered manager confirmed there were opportunities for staff to undertake additional training according to their needs and interests.

Staff attended conferences and forums when appropriate which included the registered managers forum which enabled them to share ideas and best practice. Information was not disseminated effectively to staff as we saw attendance at staff meetings was low and in one instance no staff turned up for the meeting. The reasons for this had not been explored. Staff had opportunities to network with other staff during refresher training but again some staff told us this was not easy for them to attend. A typical response was, "I do my training on line, other courses are offered but I don't have time."

Although staff were supported in their role some staff felt their support had been compromised by recent

changes in the branch and key staff leaving their positions. Some staff said they had not had recent supervisions or attendance at team meetings. This was particularly the case for part time staff. One staff who had been employed for fourteen months said they had not had an appraisal or face to face supervision. They confirmed they had received an induction, probationary review and spot checks. One staff said, "it been at least thirteen months." Another said," I completed a form and handed it back but did not get any feedback." Other staff said they did not know who their supervisor was. The registered manager stated changes to the management team had been communicated to staff via payslips and newsletters but not all staff spoken with seemed aware of this.

We looked at the scheduling for staff supervision which included shadowing, field observations, one to one office based supervisions, probationary reviews and annual appraisals. The data reviewed showed some staff getting regular support but for staff employed over a number of years there were significant gaps in the data which if accurate showed staff did not receive a supervision of their practice from one year to the next. For example, we saw one member of staff employed in 2011 had no recorded supervision until 2018 and records showed an overdue scheduled appraisal. This was the case for other staff which either meant the data was wrong or staff were not getting regular supervision. The registered manager confirmed the data was inaccurate.

We did not have concerns about staff induction except in discussion with two staff, one told us they had recently changed job roles had not been given a new job description and we were concerned that after an initial induction to clients a new coordinator was going out delivering care to people less than two weeks in post. Although experienced they had not completed their induction and did not have valid company ID or access to the log in system when arriving/leaving people's homes.

The above evidence supports a repeated breach of staffing, Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.
Various newsletters were provided to the inspector which evidenced additional training available to care staff. In addition, several staff had been assigned to complete Level 3 training in health and social care. Some staff were signed up to do specific courses in line with people's specialist needs such as multiple sclerosis and catheter care.

Staff reported receiving a good induction and this was evidenced by staff records. Staff had an initial induction in house and then accompanied more experienced staff until familiar with people's needs and paperwork on site. New staff worked through an induction booklet which covered skills necessary for care workers. Training was provided around the specialist needs of individuals such as multiple sclerosis. Office staff had completed advance training for both medication and safeguarding.

Staff training was refreshed and staff confirmed this was every year for some subjects. Staff spoken with confirmed that all the necessary training for their role and refresher training was provided but staff told us this was often provided in one four- hour session covering multiple subjects which was a lot to take in and staff found it difficult to process all the information.

People required varying levels of support with their health care needs and this was documented as part of their care plan. People received sufficient input from staff to help ensure they stayed healthy and were referred to other services as required.

People spoken with were confident that carers would notice if they were unwell and would take appropriate action. One person told us, "Yes, she alerts me to get the doctor." Other people told us carers would call the doctor on their behalf, or wait with them for an ambulance. One person told us, "They alert me to get the

doctor if they see any redness, to their skin) and they are not skimping they dry me fully." Another person said, "I've had no falls with them here. I use a wheelchair. It's just one carer when they call no lifting but they will now contact the O.T. (occupational therapist.) to see if I need a transfer board to assist me. "

We observed a staff member assisting a person. They were aware of their needs and had a good understanding that the person was prone to developing infections associated with erratic eating and drinking patterns. This was closely monitored and any suspected infection was raised with the GP. This helped ensure they received the treatment they needed to safeguard their health.

We spoke with various GP practices who could not specifically identify patients who used the service but were not aware of any specific complaints. Some professionals cited poor communication and lack of active engagement with their service. For example, there were concerns raised about medicines and the fact that these were not always returned to the pharmacy when required. Another professional told us there were services which could support the agency but they had not taken this up. The local authority did not raise any specific concerns and were satisfied that people received good care outcomes and any shortfalls in the service were identified and resolved whenever possible.

People were supported to eat and drink sufficient for their needs where this was something identified as part of their initial needs assessment. We observed staff supporting people and offering them choices around meals and drinks and leaving them in easy reach. There was guidance in people's care plans about the support they required.

The service supported people at different stages of their life and illness in innovative ways. For example, they were involved in an initiative with Norfolk County Council and the NHS to deliver an enhanced home support service. The aim was to ensure the safe and timely discharges from hospital where other providers were not able to restart packages of care. They also worked to prevent unnecessary hospital admissions. This could be from a direct referral or from a doctor. This project helped to promote people's health through prevention of hospital admission or by preventing longer than necessary stays in hospital when medically fit for discharge.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA. We found in a number of people's records there was a clear rationale underpinning staffs decision making where people lacked capacity. Staff acted in people's best interest and had done so in consultation with the relevant professionals and relatives who held active power of attorney for people. People were able gave written consent for their care and we observed staff always asking people before they delivered their care.

Requires Improvement

Is the service caring?

Our findings

At the last inspection on 13 and 15 December 2017 this service was rated requires improvement in this key question. This was because people did not always get the care they needed at the time of their choosing by staff familiar with their needs. We have identified similar concerns during our inspection on 9 August 2018. Some people told us they were happy with the care they received but some people raised concerns about individual carers and 'rushed care.' We have rated this key question as requires improvement.

People received differential care across the service which did not always meet their needs or enhance their well- being. People told us most of the carers were good and they had regular carers some of the time. This was reflected in the surveys collated by the agency. However, some people felt the level of service varied across the day and week and was not always delivered well or in line with their wishes. Some people reported feeling rushed. One relative said, "Well I think they are okay, mostly, good things are that the carers do care for him, (my relative.) and they do what they want. Sometimes they don't tidy up too well or make the bed right if they are rushing, some of them. There's not really any serious care errors but if they rush a bit they don't have time to shave him." One person told us they could not reach things and unless things were in the right place they could not access them.

People's needs were not always met by staff they had confidence in. People's choice of carer was not always respected. One person told us, "It's all pretty good, apart from the couple of carers who are not so good just a bit rough. Mostly okay but one man is a bit heavy handed, just not as gentle, it might be his age, but he's just not as young handed as the others." They had not raised this as a concern and did not wish to.

People told us when they had raised concerns about carers and their right to choose who came into their home this was not always respected. One person told us, "The best staff are more considerate, but some just lack consideration, one is a bit rude, they do know about them, they still send them. They have a bad manner. They are so short they can't get rid of them. They left and came back. I'm less relaxed and even feel a bit stressful. They talk down to me." Another person told us they had complained about a staff member and asked not to have the back but they had been back when the service was short staffed. A person using the service told us," I could not do without them having said that they do have some issues, lack of staff sometimes, they turn up late or someone I don't want turns up but they don't miss calls."

A member of staff told us that they had been asked to attend a person when the person had already said they did not want them to make their calls. This was poor practice and illustrated people's preferences were not always respected. The registered manager has said there had been a problem with the computer systems in terms of data input but this had been rectified. This may have resulted in the computer not automatically barring certain staff from certain calls.

People reported late running calls or change of carer without being informed as their main concern. Some people said contact with the service was usually initiated by themselves and not the office staff and felt they were not given enough information about who would be covering their care calls which caused them anxiety.

Staff gave us examples of how they supported people and their families particularly when people were ill or needed to be admitted to hospital. However, staff said they were not always supported by the agency particularly if they had to deal with an emergency or a death which staff said could impact on them and younger less experienced carers.

People overall said staff treated them with dignity and encouraged them to be independent. For example, one person said, "They help me have a wash then. Yes, they take the time to do that properly, no rough handling but some are gentler than others. No nothing nasty. "Another person said, "I'm very happy with them. They put me at ease." Another person told us, 'They help me wash and dress and they take the time to do it properly and they put creams on my legs. I've had falls but not with them I often stumble but when they are here they stop me falling. The care is done with dignity and safely. I don't really want a man but would do so if they were short. Another said, "They respect that I like my independence. They just help me as I wish, no more."

Staff were often recalled as doing little extras or as being thoughtful about things that made a big difference to the person using the service. This typically included the value of a quick chat, a cup of tea, or a bit of banter if time allowed.

Carers were being recognised for going the extra mile and for long service. The organisation issued a connections magazine in which it reflects stories of people they support and the carers who deliver care. A recent article was how carers battled through the snow to ensure people received their support.

Staff were encouraged to sign post people using the service to other services which might be appropriate to their needs. These could be groups like local knitting groups. The branch manager said they had also facilitated people meeting up with others when out with their carer on a shopping trip to help promote social inclusion.

People were consulted about their care plan and this was reviewed although people felt contact with the office was not always regular. We saw people had given signed consent for their care and support but care plans did not always include preferred timing of call or more personalised information about how their needs should be met in line with their preferences to help ensure carers provided them with continuity of care.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection on 13 and 15 December 2017 this service was rated requires improvement in this key question. We found a repeated breach for person centred care: Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The provider had continued to fail to plan and deliver care to people based on their individual needs and preferences. We also found a repeated breach of regulation 16 complaints. People and relatives said their concerns/complaints were not always dealt with effectively.

At our inspection on 9 August 2018 we found improvements had been made but there was sufficient evidence to support a continued breach of regulation 9: person centred care. Care plans had improved but further improvements were planned to update and standardise care documentation. Despite these improvements not all care plans were up to date and did not accurately reflect people's needs and preferences. A lack of specific information about people's needs placed people at risk of not receiving the care they needed. We were not assured care plan reviews took place when people's needs had changed. However, the branch manager told us all care plans were up to date and had all been reviewed in the last twelve months. They said when taking over work from another organisation some care plan paperwork was many years out of date.

Of the six people we visited two did not have a care plan in place, the other four people did. One person's care plan was out of date and showed no evidence of review since they first started using the service in 2015. The other three care plans were up to date but one person told us this had not always been the case. They said last year following a hospital admission of four weeks a social worker came to carry out a review on discharge and called the agency to tell them the care plan needed updating as it no longer reflected their needs since a hospital admission.

We spoke with people over the telephone, one person told us, "I agreed the care plan with them back then and since then it's been checked with me but they've not done a review for a couple of years, they are very flexible anyway. I can just call them and they will make changes." Another person told us, "At the start they came out and we agreed the care plan and times etc. it's not been reassessed or reviewed yet. I've not complained but want an earlier morning call and they will try to manage this. It's half nine at present and we could do with being earlier as I spent too long in bed."

Staff spoken with said information in the care plans was not always up to date or reflective of people's current needs or preferred choice. For example, one member of staff told us they had repeatedly reminded office staff why the person needed an early call and this did
not always happen. Staff said records lacked specific detail such as, 'Mrs [X] doesn't like crusts on her bread.' Staff said they did not have time to read the care plan but got to know people's needs over time and there was basic information on their phone However, a staff member told us they visited a person who was blind and this was not on the initial information provided on the phone.

Care staff said people's preferences regarding their preferred carers were not always adhered to particularly when the agency was short of staff. They said there was a disconnect between the care needed and the care

planned because not all office staff were familiar with the geographical area or client's needs. Care staff said care plans were not always in place when they took on new clients. However most staff said the care plans were easy to understand, and nice and clear.

The care plans we reviewed had some information in but this varied in terms of its quality and some information was out of date. For example, we saw a list of contacts in the agency user guide for people to contact if they had any concerns about the service. Some of these staff
who had left and were no longer contactable.

We looked at a sample of audited daily notes and found some gaps. For example, some days a visit should have occurred but could not be evidenced by the record as there were no daily notes. This had not been identified by the audit and we could not see if the persons needs were met. For this reason, we looked specifically at their care plan. Although their needs had been reviewed there were gaps in their medication records and daily notes. Their care plan did not include details about their skin integrity or more information about 'burns' which notes said the carers were applying cream to. This meant we were not assured what their specific needs were or how they were always met. For another person notes were not legible, there was considerable variation of call times and notes had only been reviewed up until May 2018 and this was not done until July so was not up to date. A third persons notes showed at least seven different carers visiting them and call times varying by an hour and a half.

The above supports a continued breach of Person centred care regulation 9: Of the Health and social care 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were mostly satisfied with the way their care was provided and had formed strong bonds with their regular carers. One person told us, "I can cancel sometimes if I'm going out. They are very flexible if I need to change the times. "Another person said, "I would recommend them very much but not to lose her. I could not manage to live here without her and them helping me. I'm now able to get out. "(by her the person was referring to their regular carer.) Another person told us, "I have just one carer visit each morning but in the evening, I get different staff and they are ok but it would be better if it was the same person. "This was the experience of a number of people we spoke with. We noted that, where there had been spot checks on how staff supported people, these reflected how they had communicated with people in a way that they understood, as well as asking them about their care.

At the last inspection 13 and 15 December 2017 the service was in breach of regulation 16: Complaints. This was because people and relatives had expressed concern about how their complaints were responded to and addressed.

At our inspection on 9 August 2018 the service had improved in how it dealt with complaints. However, we could not see if all complaints had been resolved in a timely way or how effective the service was in responding to people's concerns.

There were 21 complaints recorded since the beginning of the year, six were logged in June and July 2018 from people using the service and related mainly to scheduled visit times.

The registered manager had a system for reviewing complaints to see if lessons could be learned. They had analysed complaints in April 2018 to establish any patterns and identify where they could make improvements. More recent complaints had not yet been reviewed to see why six of the 21 had been received within the last two months and whether there were factors influencing this. The registered manager said they would be reviewed soon but we felt a timelier review might help demonstrate the agencies

responsiveness. We found that the records included information about the nature of the complaint, together with correspondence and outcomes where they were resolved.

However, not all complaints had been concluded, based on the complaints log in use. For example, we found details of one complaint recorded on the log sheet as opened on 21 March 2018, but not showing on the log as resolved at all. A further complaint was logged as received on 22 June 2018 but resolved on 5 June. We concluded this was likely to be an error and should have read 5 July. However, we also found one complaint logged as opened on 21 February 2018. Records about the complaint itself showed that the investigation was not properly underway until June 2018, when an interview took place with a staff member on 25 June. This indicated that there was a potential delay in not only dealing with the complaint, but also in resolving it. We noted that, in one case, a person had complained about their care plan because they felt it did not accurately reflect their needs and the manager was investigating this together with a delay in providing the information to the person and seeking their agreement. This meant the agency were still not sufficiently responsive to people's feedback in helping them to improve the service.

There was an established complaints procedure which was accessible to those using the service and their relatives. The registered manager said it could be reproduced in different languages or large print if required.

There was clear guidance for staff about what they needed to do if they received a complaint. This included that complaints could be made verbally or in writing and how staff needed to record, log and pass them on.

Information about how people could make a complaint and who they should contact, was contained within the guide for people who used the service. We saw copies of this in people's homes. This included information about referring concerns to the local authority or to the ombudsman if the agency did not respond appropriately. The process set out timescales for when people could expect to receive an acknowledgment and resolution of their complaint, or an explanation for any delays.

People spoken with generally felt they could contact the office and raise concerns if they had them. Several people spoke of improvements to the service of late. One person told us, "They do listen to me. I've not had to complain much, once had to change a worker just once. They responded without a fuss."

The service supported people for as long as appropriate to do so and in line with their individual needs and preferences. Some staff had expressed concern that they had not had end of life training. Documentation around end of life, preferences and wishes varied according to the persons needs and their willingness to discuss it. There was information about what was important to people such as their cultural and religious beliefs and we saw some do not attempt cardiopulmonary resuscitation in place for people in a prominent place in the care plan so staff should be aware.

Inadequate

Is the service well-led?

Our findings

In April 2017 we inspected this service and found five continued breaches of regulation of the Health and Social Care Act 2008 (Regulated Activities) 2014. The service was not employing enough staff to meet people's needs. Risks to people's safety were not sufficiently assessed or managed and people's care had not been planned or delivered to meet their individual preferences. There was poor oversight of complaints and the provider's governance systems were ineffective. We sent the provider a warning notice telling them that they must have adequate governance processes in place by 30 June 2017. The provider requested an extension to this deadline to 30 August 2017.

We inspected the service again on 13 and 15 December 2017. We identified the same breaches of regulation as the previous inspection. These were breaches for staffing levels, safe care and treatment, person centred planning, management of complaints and good governance. We rated the service as requires improvement overall, inadequate in well- led and placed the service in special measures. We do this when services have been rated as Inadequate in any key question over two consecutive comprehensive inspections. The Inadequate rating does not need to be in the same question at each of these inspections for us to place services in special measures.

At our inspection on the 9 August 2018 we found the service was not consistently well led and well planned which meant the outcomes of care for people were variable. It also meant improvements made were not firmly embedded within the culture of the service.

In recent years a number of branches had amalgamated and now come under one branch. For some staff this had a negative impact in terms of the organisation, their work load and the support they received. One staff member said, "The company has got too big and when that happens you lose something, there is a lack of continuity, I don't know who they are, or what they do, they are faceless."

There was a registered manager and a branch manager in post but plans were in place for the registered manager to go back to their former post of area manager and the branch manager to apply to be the registered manager. The branch manager was being supported in their new role. However, we found a disconnect between care staff and staff in more senior roles. Staff told us care- calls were not well coordinated which had an impact on the delivery of care. They said they did not always feel well supported and communication from the office could be poor. For example, one member of staff said they did not know who worked in the office and what their roles were. Recent changes to teams had impacted on staff morale and affected the level of satisfaction of people using the service.

On our first visit to the office there were a number of temporary staff who had been employed from an outside agency as two care coordinators had left and another was off sick and leaving by the end of the following week. There were two new care coordinators who had started, one was out shadowing, the other came to the office to shadow senior staff. Senior staff were planning people's calls but also covering care calls as they said they were short of carers due to recent leavers and staff sickness. This had an impact of their primary role and time to adequately plan the service.

A care coordinator from another office was helping and scheduling calls for the forthcoming weekend and the week ahead. They told us these were done a week in advance but there had been a problem with the computer systems so on the Thursday they were still planning calls for the weekend. Computer problems meant data relating to regular scheduled visits had not been pulled across to the following week and had to be added manually interrupting the work flow.
Forward planning was made more difficult because staff were new to their roles and did not have the soft intelligence which would help them plan more effectively. We were informed by care staff on our second visit and people using the service that the weekend of the 10 August was chaotic and calls ran very late for some people.

The out of hours on call system was not working effectively. The on-call was held by senior staff one for each area. The on-call policy said this had to be planned at least a week ahead and the registered manager said this would be indicated on the calendar. However, it was not and staff told us they just communicated between themselves who would be covering. The on-call was changing to one person holding the on-call for three areas and a separate on call for the fourth area. The rationale for this was not clear, neither had it been clearly communicated. When we questioned if this would be manageable we were told the number of calls was low and the times the on-call person had to attend the site was rare. On call staff recorded in an on- call log and then later transferred this to the electronic record or staff would record directly on the computerised records. This might not give an accurate picture of the number of calls received. The log showed a different variation of calls with some locations logging higher number of calls, but all were appropriately actioned. The call log indicated a number of falls and how these had been followed up and a few entries of late running calls which were flagged up by people using the service as opposed to carers. Staff said they could not always contact the on-call person and their calls were not always returned.

There was a record of missed calls and an analysis of why these had occurred so the agency could take appropriate actions. From January to March 2018 there were 19 missed calls and from April to June 8 missed calls. These had occurred because calls had not been allocated or had been overlooked by staff. The calls analysis log stated welfare checks were made to people to establish their well- being but the outcome of this visit was not recorded on the analysis log.

Recruiting enough staff to manage the business was not yet effective. The agency had vacant posts and only a few bank staff who could pick up shifts as required. The agency had an emergency contingency plan which relied on using agency staff if required or handing back care packages if necessary. We found some staff were working excessive hours and had insufficient time to travel between calls, which meant they were either rushing the client or cutting the care call so they did not get the full time they were entitled to. This was evidenced through the rotas which had minimal or no gaps and by staff who raised concerns about their working practice.

Office staff could be rostered on to cover calls, as we saw on the first day of our inspection on 9 August. A care staff had rung in sick and the auditor went to cover the calls. They told us they had also been out the previous week. This had an impact on their main role and was indicative to us the service was not deploying people effectively or using agency staff to cover calls.

Recent changes within the staff team had not been well communicated. Some staff said they were unaware of who would be doing spot checks on their performance or supervisions. The experience of carers varied according to which area they mainly covered and who their coordinator was which gave the impression of a disjointed service with poor management oversight.

Communication across the team was poor although the registered manager and the branch manager felt

this was an area where they had significantly improved. The electronic monitoring system enabled the management team to monitor calls and provided safeguards for carers in terms of knowing where they were at any one time. However, staff said information was not communicated effectively. The branch manager told us monthly letters were circulated with staff's time sheets highlighting any changes within the service and we were shown examples of these. Staff said they did not receive every month and said staff meetings were scheduled infrequently. Some staff felt unable to attend staff meetings due to work/family pressures and said they did not receive minutes of meetings. Each area met separately and we saw poor evidence of sharing and learning across the teams. In one recent scheduled meeting no staff attended at all which is indicative of wider problem.

Written communication in the office required improvement as we saw many examples of paperwork which was not dated or signed. We found information was not immediately forthcoming when requested as part of our inspection. We gave the service 48 hours' notice of our inspection and asked for some information. This was not produced ahead of the inspection and we found both the registered manager and the branch manager not proactive in having information ready for us to review. We spoke with the branch manager and suggested information could be submitted at any time to CQC to demonstrate ongoing actions and improvements the service was making to become compliant and they did not have to wait for the inspection. We raised concerns about the data contact sheet they sent us ahead of the inspection as numerous contact details of professionals were incorrect. This made it difficult for us to contact people/stakeholders and professionals for their feedback and presumably this would also be the case for senior staff when they tried to refer to other agencies.

People spoken with raised concerns about poor management. They told us carers often discussed with them what was happening in the office. This is a breach of confidentiality. When we were out on visits carers discussed who else they visited in front of people, again this is a breach of confidentiality. We asked people about their experiences of contacting the office. They told us they could get in touch with the office and staff were easy to get on with, but did not always pass on messages or let them know if staff were running staff or about changes to their rota. Further evidence of this was provided from the complaints log, on-call log and as an outcome of recent surveys where half the people who responded felt the contact with the office had not been satisfactory.

The registered manager oversaw a number of large branches, a second branch was recently rated inadequate overall. We discussed this as part of our feedback and sought assurances of how the provider intended to support its managers and improve its service provision.

The above supports a continued breach of Good governance: regulation 17: of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service considered feedback from people who used the service and regularly reviewed and monitored the service they delivered so they could recognise what they were doing well and lessons they could learn when things had not gone so well. We found the underpinning quality assurance systems were not yet sufficiently robust in driving improvement.

We met with the head of quality who supported staff to improve the quality of the service and to develop robust quality assurance systems. We also met the branch quality officer. The role of the branch officer was to carry out record audits and review medication records. This was to check the quality of the information recorded and to assess any anomalies within the records. The branch officer told us audits were up to date in recent weeks because temporary staff had been used to clear the back log. This meant audits had not been completed in a timely way which meant errors particularly regarding medication had not been

identified in a timely way.

Care plans and other records were not all up to date to help staff provide personalised care. The branch manager told they were all up to date but we did not find this. Both electronic and paper records were kept and we found paper records were not always in sufficient detail, generic and lacked sufficient personalisation. They did not all show evidence of recent review. People had raised concerns as part of the branches recent internal survey that they had not had regular visits from the office staff to review their needs. The service carried out a percentage of their reviews on the telephone and some face to face which might account for why people said they did not see staff. We found some people we spoke with were difficult to communicate with due to poor hearing and cognitive issues. These were people the agency had identified to us as being able to speak over the telephone and the agency carried out internal reviews in this way This meant information collated using this method might be unreliable. The branch manager said that head office completed telephone surveys with a sample of people monthly. They kept a log of actions where individuals had raised issues, to show how these had been addressed. We did not see these.

The head of quality supported the branch in making necessary improvements and identifying themes and trends across their regulated services. They met at regional level to discuss new initiatives, share best practice and learn lessons across a wider area. We asked for examples of improvements they had identified and were working to improve. They told us one of the reoccurring themes from inspections across Carewatch was that care plans were not sufficiently person centred. As a result, a working party had completed a full review of documentation and the company had designed a completely new format for care plans. The focus was much more person centred. Training was being rolled out to all key staff in the organisation in July and August of this year and the new care plan format was beginning to be introduced into client's homes. There were not clear timescales for completion of this work.

Quality assurance surveys were sent out to people on a regular and rotating basis. For example, in June, surveys were sent out to 25% of people using the service, data was analysed, interpreted and action plans put in place when necessary. In June 2018 there was only one respondent. Some people we spoke with were aware of surveys, others not. In direct contrast in May 2018, 73 surveys were sent out, 17 were returned from people using the service. This gave more reliable data and indicated people were mostly satisfied with areas of their care and support. However, some concerns were identified including 53% of people had not received a call from a senior to check the care was being delivered as planned, 50% of people had received an inadequate response from office staff and 16% did not feel staff were sufficiently trained. In April it does not record how many surveys were sent out but 4 were returned. We were unable to see how the service used this data to improve the service.

We spoke with the local authority monitoring team whose view was that the quality of service has improved and stabilised over the last few months. They said they had worked closely with the registered manager and branch manager to monitor progress against their action plan. They said the branch had always kept them appraised of any changes in operational delivery for example, any restructures or changes in key staff within the management/office team. Quality improvement plans were live and demonstrated quality issues, concerns, areas of non-compliance, including any actions coming out of local authority audits, regulatory inspections, internal audits and quality reviews, H&S audits etc. These were kept up to date.

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 9 HSCA RA Regulations 2014 Person-centred care Not all care plans were up to date or used by care staff in the way that was intended to deliver safe care around the persons assessed needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment We were not assured that people always received safe care and treatment because records and audits were not sufficiently robust. We also had concerns about the poor planning and delivery of care and the implications this might have on people's safety.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had improved since the last inspection but was still not delivering safe, effective care across the whole service. People experienced differential outcomes of care and the poor deployment of staff placed people at risk of harm.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not enough staff to provide the care and support to people according to their

preferences and assessed needs. We were not assured staff always received sufficient support for their role and personal development.