Care Precious Ltd

Caremark (East Riding)

Inspection report

4 Priory Court
Saxon Way
Hessle
East Riding of Yorkshire
HU13 9PB

Tel: 01482579579
Website: www.caremark.co.uk/eastriding

Date of inspection visit:
28 July 2016
05 August 2016

Date of publication:
07 October 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

Caremark is a domiciliary care service operating from offices on a business park in Hessle, in the East Riding of Yorkshire and also close to the city of Hull. It provides care and support to adults of all ages with a wide range of care needs, including memory impairment, old age, learning disability and physical disability, as well as some needs associated with medical conditions. There are over 650 people receiving care and support, and around 360 staff working for the service providing 6000 visits per week.

The inspection took place on 28 July and 5 August 2016. The inspection was announced; the provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office who could assist us with the inspection. At the previous inspection completed in March 2014 the service was complaint with all the regulations in force at that time

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the CQC 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.

The registered manager had not informed the CQC of all significant events as required by regulation. This meant we could not check that appropriate action had been taken. This was a breach of Regulation 18 of the Registration Regulations 2009.

We found that staff had a good knowledge of how to keep people safe from harm and there were enough staff to meet people's needs. Staff had been employed following appropriate recruitment and selection processes. However, DBS checks had been missed for two care workers who were recently employed by the agency. We have made a recommendation about this in the report.

We found that people's needs were assessed and risk assessments put in place to keep people using the service and staff safe from avoidable harm. We found that the administration of medicines was being audited; however, we identified that some recording issues had not been followed up, although the service had implemented a system to address this.

We saw that staff completed an induction process and they had received a wide range of training, which covered topics including safeguarding, moving and handling, first aid, infection control and an introduction to dementia. Staff told us they felt well supported; they received supervision and attended 'patch' meetings. Staff were also encouraged to complete the NVQ/QCG Level 2 in health and social care or higher. Staff received training on the Mental Capacity Act 2005 and had knowledge on this topic sufficient for their role. Staff told us they felt well supported; they received supervision and attended 'patch' meetings.

Some people told us they received support from staff with shopping, cooking and domestic tasks. They were

involved in choosing what items they wanted staff to buy or what they wanted to eat and were generally satisfied with the meals prepared. People were supported to access healthcare support where necessary.

People told us that staff were caring and that their privacy and dignity was respected by the agency's staff. People's independence was promoted and most people said they received care from a regular group of carers. People were supported to access the community when this was included in their care plan.

We saw that people's needs were assessed and care plans put in place to enable staff to provide responsive care and support. People had been involved in the planning of their care and relevant people were included in care plan reviews.

People were supported to make choices and decisions and to feedback any concerns. There were appropriate complaints procedures in place should people need to raise any issues.

Most people using the service and the agencies staff told us the service was well-led. We could see there were systems in place to monitor the quality of care and support provided and evidence that action was taken to address any concerns.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff displayed a good understanding of the different types of abuse and had received training in how to recognise and respond to signs of abuse to keep people safe from harm.

Risk assessments were in place and reviewed regularly which meant they reflected the needs of people receiving a service from the agency.

There were sufficient numbers of staff employed to meet people's assessed needs and appropriate recruitment practices were in place. However, DBS checks were missed for two members of staff.

Systems were in place to ensure that people received their medication safely and as prescribed by their GP. Medication records were audited monthly to check for accuracy of recording. However, not all recording errors were followed up.

Is the service effective?

Good

The service was effective.

Records showed that staff completed training that equipped them with the skills they needed to carry out their role.

Staff received training on the Mental Capacity Act 2005 and understood the importance of seeking peoples consent.

People told us that their nutritional needs were met and that they were happy with the support they received with meal preparation.

People had their health and social care needs assessed and health care professionals were contacted if people's health deteriorated.

Is the service caring?

Good

The service was caring.

People told us staff were caring. Staff knew people's preferences and they responded to people in a kind and caring manner.

People were supported to make decisions about the care and support they received and their independence was promoted.

Is the service responsive?

Good

The service was responsive to people's needs.

People's needs were assessed and continually reviewed which meant that staff were aware of their up to date care and support needs.

People's individual preferences and wishes for care were recorded and these were known and followed by staff.

People told us they were happy to discuss any concerns with the agency's staff and knew how to make a complaint if needed.

There was a complaints procedure in place and we saw that complaints received had been investigated appropriately.

Is the service well-led?

Requires Improvement

The service was not always well led.

The CQC had not been notified of all significant events that occurred at the service. This meant we could not check that appropriate action had been taken.

The service had systems in place to monitor and improve the quality of the service.

Staff told us they felt well supported and could approach the management team with any issues or concerns.

Caremark (East Riding)

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 registered 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.

The inspection took place on 28 July and 5 August 2016. The inspection was announced; the provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office who could assist us with the inspection. One Adult Social Care (ASC) inspector carried out the inspection.

Before this inspection, we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authorities that commissioned a service from the agency. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted the local authority safeguarding adults and quality monitoring teams to enquire about any recent involvement they had with the agency.

The registered provider was asked to submit a Provider Information Return (PIR) before the inspection, as this was a planned inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. The registered provider submitted their PIR within the agreed timescale.

As part of this inspection, we spoke with 42 people using the service by telephone. We also spoke with two relatives to ask them for their views of the service. We visited the registered provider's office and spent time with the registered manager, the compliance manager, the company director, three care coordinators and six care support workers. We also spoke with four members of staff on the telephone.

We looked at three people's care records, three staff recruitment and training files, the service's electronic care planner system and a selection of records used to monitor the quality of the service

Good

Is the service safe?

Our findings

People told us they felt safe. Comments included, "Oh yes, I feel safe, they are very good", "I feel very safe, when I am showering they are there to support me" and, "It is nice to have a visitor each day as well. I believe the staff are all trustworthy and I feel safe when they are here helping me."

The staff we spoke with told us they had completed training in the safeguarding of vulnerable adults and they were able to explain the types of abuse that people could experience and the action they would take if they had any concerns. One member of staff said, "If I saw anything that wasn't right I would speak with the supervisor or go straight to the manager. If it wasn't dealt with I would speak to social services." They added, "I've never had to though." Another said, "I did see something that concerned me, it was reported to my supervisor and after an investigation the person was dismissed. It's given me the confidence that issues will be dealt with." Staff were informed about the agency's whistle blowing policy as part of their training and the policy was also included in the staff handbook. Staff told us that they would not hesitate to use this policy if they had any concerns about a colleague's practice.

The service had policies and procedures in place to guide staff in safeguarding people from abuse. The registered manager used the local authorities safeguarding tool to decide when they needed to inform the safeguarding team of an incident, accident or an allegation of abuse. We viewed safeguarding records and saw that safeguarding concerns were recorded and submitted to the safeguarding team when appropriate. However when we viewed the services incident log we found that some events that had been investigated by the police had not been reported to the Care Quality Commission (CQC) as part of the registered provider's statutory duty to report these types of incidents. This was a breach of regulation and has been addressed in the well-led section of this report.

The registered provider had systems in place to ensure that risks people could be exposed to were minimised. Care plans contained risk assessments to identify potential risks to people using the service and staff. This included risks for the internal and external environments, any equipment in situ and potential risks to people using the service and staff including slips, trips, falls and food storage. These assessments listed the type of risk, who was at risk and what actions had been taken to eliminate or reduce the risk. Some staff employed by the service were required to drive between calls and take the people they supported out in their own cars. We saw the agency had ensured that all staff who were required to use their cars had a current valid driving licence, a valid MOT certificate and the correct insurance to enable them to transport people as part of their occupation. This meant that people were protected from any risks associated with being a passenger in a staff member's motor vehicle.

We asked the registered manager how they ensured there was sufficient numbers of staff to meet the needs of the people using the service. We were told that the registered provider was aware of the need for continual recruitment to ensure they had sufficient numbers of staff to meet the needs of an expanding service. We saw that group induction sessions were completed regularly, which meant they always had members of staff ready to step in when vacancies became available or when new referrals were received for support services. One of the care coordinators told us that the number of calls required and the number of

staff needed at each call were all taken into consideration before the package of care was agreed. These steps helped ensure that sufficient numbers of staff were available to meet the needs of the people they supported.

We checked the recruitment records for three members of staff. Application forms were completed, references obtained, identification collected and checks made with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and ensured that people who used the service were not exposed to staff that were barred from working with vulnerable adults. We saw that new staff were required to sign a health declaration form to confirm they were physically able to carry out the role. We noted that one member of staff's interview record had not been scored by the interviewer. To ensure that the process is as robust as possible all elements of the documentation need to be completed.

Following the inspection, we received some information of concern in relation to a member of staff working without a current DBS check. We asked the registered manager to investigate this and they confirmed they were aware of two staff members who did not have a valid DBS check at this time. The registered manager told us, "Caremark undertake DBS checks for all new care staff before or during their induction training. We were aware of this issue as it has been picked up during an internal file audit and as a result, both members of staff continue to work on two carer calls only, whilst we await the outcome of the DBS check."

We recommend that the registered provider seek advice and guidance in relation to the robustness of their recruitment process.

The agency had a business continuity plan which recorded how issues such as severe weather, unusual levels of absenteeism, utility failure and external influences such as industrial action, fuel shortages, theft or fraud, could impact on service delivery. We saw that all customers had been risk assessed and those whose care requirements were deemed as essential would be prioritised during any break in normal service. The plan provided clear strategies the service could utilise to minimise the impact of any such event on the people using the service and to enable the service to continue to operate effectively in the event of unforeseen circumstances.

The registered provider utilised an electronic call monitoring system that enabled them to track the time people's calls started and finished in 'real time'. The staff providing services in the East Riding were required to call from the telephone of the person who was receiving the call, whilst in Hull the staff were required to log in and out of each call through an application on their mobile phones. The registered provider was able to set tolerances which would alert the care co-ordinators in the office if a call was more than 15 minutes late or had been missed. This meant they were able to take action to ensure that both the customer and the member of staff were safe. People were able to opt out of the call monitoring if they wished and in this instance the registered provider would be reliant on the person to 'flag up' any late or missed calls.

People who used the service told us that the carers were usually on time. Comments included, "The girls are always on time", "They are usually on time and if they are not somebody gives me a call to let me know they are running late", "They are on time or near enough, it's not an issue" and, "Only once they have not turned up, but that member of staff has been moved on now." However, one person said, "I've never complained though I was disappointed once when no one showed up, so I spoke up then. I had a written apology from high up in the company." We discussed this with the compliance manager and they told us, "If a customer experiences a missed call then we take this very seriously and each individual case is investigated. When we discover the reason then we take action to try and reduce the chance of this happening again." The missed call audits we viewed confirmed this.

Staff had training on the administration of medication as part of their induction training. Two local authorities commissioned a service from the agency and they both had different medication training requirements. However, some concerns were raised regarding the quality of the training provided by one Local Authority, therefore the decision was made for all staff to complete medication training with the Local authority the service had most confidence in. Records evidenced that staff had attended appropriate medication training during their induction period, and as refresher training on a regular basis. We saw that medication spot checks were carried out and this provided an additional opportunity for the field care supervisor to observe staff giving medication in people's homes and determine whether they were competent or if additional support / training was required.

The registered provider had a medication policy in place and the regional manager told us that all staff received training in medication management prior to administering any medication in people's homes. The staff we spoke with confirmed they had received training and told us they felt confident with the process. One person said, "During the induction we receive training on how to administer medication and record it correctly on the MAR chart. I find it quite straight forward." However, one member of staff said, "I enjoyed the induction, but wished that we had a bit more support with medication in people's homes. The training you get is fine, until you come across something like a recording error, then you are a bit unsure what to do…I just rang my FCS (Field Care Supervisor) and they talked me through it." The compliance manager told us, "If people feel they need more training on any subject then all they need to do is ask and we will arrange it for them."

The compliance manager told us that medication administration record (MAR) charts were returned to the office on a monthly basis and a selection were checked for accuracy. Any gaps or anomalies were cross-referenced against the diary records to identify an appropriate explanation. If a suitable explanation was not found, then the compliance manager was able to identify the member of staff who attended the call and the issue could be addressed. However, when we viewed a selection of MAR charts at the office we found that gaps were present and no follow up action had been taken. We discussed this with the compliance manager who informed us that it had been recognised that the number of MAR charts they were able to audit was not sufficient. In response, they had implemented a medication error alert form that all members of staff could complete to flag up any errors at the earliest opportunity. It was hoped that by continually reinforcing the need for accurate recording through patch meetings, supervision, staff newsletters and spot checks in people's homes that the service could make improvements in this area.

We saw that when more serious medication errors had occurred the causes of the error were fully investigated and where a member of staff was found responsible, supervision was held and additional medication training was provided to the member of staff. This showed the service recognised the importance of ensuring the number of medication errors was reduced.

Good

Is the service effective?

Our findings

We looked at the induction, training, supervision and appraisal records for three staff. We saw that staff had completed an induction which included a week's training at the head office covering several topics such as moving and handling, medication, safeguarding, infection control, food hygiene, fire safety, dementia awareness and basic first aid. All of the staff we spoke with were enthusiastic about the induction they received and felt it covered all the key areas.

Before working alone staff were required to complete a number of shadow shifts where they observed a more experienced member of staff carrying out their role. The registered manager told us that new staff had three shadow shifts as a minimum but if staff wanted more they would accommodate this. One member of staff said, "I completed three shadowing shifts after my weeks training, I felt that was enough for me as I was quite confident." Another said, "The induction taught me all I needed to know. I then had a couple of shifts shadowing but as I had worked in care before I was already quite confident."

Once the registered provider's induction training was completed, new staff were required to complete the Care Certificate. The Care Certificate is an identified set of standards which social care and health workers adhere to in their daily working. It covers 15 topics including, for example, understanding your role, duty of care, privacy and dignity, safeguarding and infection control. Following this staff were encouraged to enrol on the Health and Social Care NVQ/QCF Certificate. One member of staff said, "I loved the induction and they (Caremark) have offered me more training since. I'm doing my level 2 (Health and Social Care NVQ/QCF), I really enjoy it." We checked the staff training matrix and saw that staff received regular training. Where people required refresher training in any of the topics they were sent a reminder to either complete an on line course or they were booked on to a training course at the head office. One member of staff said, "We get a reminder when training is due, but as they now pay us to attend I think all the staff are much happier about attending." In addition to the formal training Caremark also provided their staff with a quarterly adult social care quiz. The quiz followed a different theme each quarter and addressed issues such as safeguarding, Mental Capacity Act 2005 and medication. Staff were requested to answer the questions and submit their completed quiz sheet to the office with a randomly selected winner receiving a hamper.

Staff told us they felt well supported by the management team and received regular supervision. One member of staff told us, "If I have any concerns I usually discuss them as and when they occur, I get on well with my supervisor so can speak to them about anything." Another said, "We have formal supervision, it's a good opportunity to discuss any concerns, and they check to make sure we are up to date with training. The best part is they give us feedback about how we are getting on, sometimes it's good and sometimes it could be better, but it makes me better at my job so I don't mind." However, one member of staff felt the supervision process was a 'tick box exercise' and did not really address any of the issues they had. We viewed staff supervision records and saw that well-being, working hours, clients, staff, training and performance were all discussed. Feedback was given and any important business updates were shared.

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 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 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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection. We checked whether the service was working within the principles of the MCA and found that people using the service did not have any restrictions in place at the time of this inspection and that no applications had been made to the Court of Protection.

We saw that staff were in the process of completing MCA training and dementia training as part of their induction and on-going training. Staff told us that although most people they supported had capacity they recognised the need to request people's consent before carrying out any care tasks. A member of staff said, "It's important that people agree to the care I provide, I ask them if they are happy for me to carry out a task, if they say no I respect that. If they refuse often then I would speak with my supervisor for advice." Another said, "I provide support for one client and they forget things instantly, so I have to ask them each step of the way to make sure they are happy with what I am doing."

Some people who received a service required support with shopping for food and the preparation of meals and drinks. The amount of support required varied from person to person and most people were satisfied with this aspect of the service. One person told us, "I usually buy ready meals so all they have to do is pop them in the microwave for me. I am quite happy with them." Another said, "It is not easy for staff to cook in half an hour and the younger girls that come at tea time usually only do me a sandwich. I help where I can by putting the oven on and maybe putting a pie in so staff just have to do my veg." A member of staff said, "If I am on a long call then I will cook them something from scratch, if it's only half an hour then they usually have ready meals." We saw that when staff were concerned about people's weight, food diaries were put in place to measure the amount food people were consuming, usually under the guidance of the district nursing team.

Staff monitored people's health and ensured risks to their health were minimised. Information about each person's physical health needs was recorded in their care plan, including specific details of any known health care conditions. If staff suspected that a person was unwell this information would be recorded in the person's daily diary. Staff would contact the office who would in turn speak with the person or their family to determine whether the GP needed to be called. People told us that if they needed a carer to support them to attend health appointments then this could be arranged. One person said, "The carers are flexible, I have lots of hospital appointments and need them to take me. They adjust my calls to suit my appointments." These steps helped ensure that people's health was monitored.

Good

Is the service caring?

Our findings

People told us the staff were caring. Comments included, "I am very happy with Caremark. The carers are brilliant. I was quite stubborn when I was ill, but I've had a lot of the same carers from day one and they have brought me on", "I think people are just so very nice, pleasant, helpful and calm. I like my visitor every day and look forward to it very much. It is lovely to have someone call to see me", "The staff are good company, they are more like friends than carers", "The carers are lovely, every one of them" and "Some of the carers are brilliant, they are like family to me." However, one person told us that they had experienced a care worker have an altercation with another care worker in their own home. They told us this had been reported to the service, and the care worker did not come back. We discussed this with the registered manager who told us that this incident had been discussed with the member of staff involved and they had been withdrawn from providing care for the person. We saw documentation that supported this.

People told us that having a regular member of staff or group of staff attend to their care needs was important to them and when this happened their care was generally good. Most people were satisfied with their group of carers, although one person felt that recently the number of different carers they were receiving had increased. They explained, "Just recently we have had lots of new carers, last week we had eight different carers, it's too many, every time a new one comes we have to tell them what to do." We discussed this with the registered manager who told us, "In July Caremark took on a bulk transfer of care packages from another provider who was unable to continue to provide these. We also had an issue with two care-coordinators who we put in place to provide support coordinating these new packages of care, however they did not meet the benchmark so were released during their probation period. This has caused some issues, but we now have an established supervisor in place and we have also put a hold on new packages in some parts of the city of Hull until we have stabilised the bulk transfer of work we took on."

Most people who used the service told us they had control over their care. One person said, "I decide what I want for my meals, my carer takes me to the shops and we pick the food we need to cook my tea and we prepare it together when we get home." People told us that if they were unhappy with any of the carers that attended, then they were able to request that they did not return. We discussed this with the care coordinators and they explained that each carer had a compatibility rating for each client. If they had a low rating then the system would prevent the member of staff being allocated to that client. This helped ensure that people received care from members of staff they liked.

When there was a planned change of staff for a person due to somebody leaving, the care-coordinators would try to make sure the person had met the new member of staff before they started working in their home. However, they acknowledged that when it was extremely short notice due to staff sickness, this was not always possible. One person told us, "We don't always get a meet and greet, which can make it a bit awkward." Another said, "I've got new carer coming on Tuesday, they are coming with one of my other carers to be introduced to me and they can show them what needs doing." The registered manager told us, "Caremark policy is to introduce all new clients to care staff; however the duty of care takes over when covering sickness and holidays and unfortunately it is not always possible."

Staff told us they encouraged people to be as independent as they could be. One member of staff told us, "A lot of the people I support are fairly independent so can do most things for themselves. If I have a new client I ask what they are able to do for themselves, if they tell me nothing I look for simple tasks such as washing their own face, sometimes it's these little things that matter." One person who used the service told us, "I try to do as much as I can for myself and the staff encourage me to be independent, but they will help when I am struggling."

People told us they felt staff treated their clients with dignity and respect. A relative said, "They are very discreet when helping with personal care and respect my parents' dignity. Staff always make sure my parents are covered up when being supported and they help them with personal care in the privacy of the bathroom" and "When they first started coming to give care it felt very funny having strange people in my home, but now I see the staff as part of the family. It gives me a break when they come." One person who used the service told us, "The staff are good listeners, we chat and together we put the world right. They are more like companions to me. They always ask for permission to use stuff in the house, when helping with meals and they even ask permission to use the loo if they need it. They are good lasses, because I've got them trained you see."

Care workers told us that they usually received sufficient information from care coordinators prior to visiting new people who used the service. The information was passed to them by telephone and it was available in the person's care plan. People told us that care workers recorded information in their care plan at each visit and this helped staff to be aware of their current care needs. The compliance manager told us that daily record sheets were returned to the office periodically so that they could be checked. This enabled office staff to check that any concerns identified by care workers had been passed to care coordinators, and that recording was respectful and accurate.

Good

Is the service responsive?

Our findings

Short-term plans of care were put in place whilst full care plans were developed. This ensured that staff going into people's homes had some basic information to guide them on the type of support they would be expected to provide. We found that individual needs assessments were then completed and person centred care plans were developed to meet the assessed needs of people using the service. The needs assessment was based on information gathered from the person themselves, from their relatives and from the support plan provided by the local authority that commissioned the service (when they funded the care package or were involved in the person's care). Care plans provided information about those areas that people required support with, including mobility, personal care, medication, health care needs, eating and drinking and accessing the community. The plan listed what the person wanted to achieve and how the support provided would enable them to realise this goal.

People we spoke with told us they had been involved in the development of their care plans, that a copy was held in their home and that the service's staff wrote in their daily diary after each visit to record the tasks they had completed. The registered manager told us, "All of our care packages are reviewed. We operate a traffic light system that ensures customers who have higher levels of need will be reviewed more frequently than those customers who perhaps only have one or two calls per week." People told us they received regular reviews and this generally happened when the field care supervisor dropped in and carried out a spot check on the staff member. Three people told us that the supervisor often dropped in unannounced and they would prefer it if they contacted them in advance. They also said that they did not feel comfortable discussing the quality of the care they received whilst the care worker they were discussing was present. This information was fed back to the compliance manager and they said they would discuss this with the field care supervisors to ensure that people felt they were able to talk openly about the care they received.

A number of people we spoke with told us they had care packages in place that enabled them to continue to access their local community and they still enjoyed visiting the local shops and other areas that interested them. One person explained they were solely reliant on staff to go outdoors saying, "Because of my condition I am unable to hear the traffic so I never used to go out. The staff make me feel much safer; if it wasn't for them then I would be stuck in my house." Another said, "The staff are great, if I am running short of anything then they pop to the shops and get it for me. They also take me out shopping to the local shops; it gets me out of the house and lets me choose what I want." A member of staff told us that they had recently taken one of the people they supported to visit the Yorkshire show and often took them to visit Hornsea. Another told us, "I have some really active clients so get out and about as much as we can. We go to the cinema, horse riding and swimming." This showed that people were supported to engage in activities of their choice.

The registered provider had a complaints policy and procedure in place and people who we spoke with told us they knew how to make a complaint and most told us they had not needed to. Comments included, "I've never needed to make a complaint but if I did I would speak with the supervisor, they would sort it out for me, all they care about is their clients", "I've never complained, but if there is anything to be said I just tell the person. For example, the office was late with the rota this week, but I finally got it. I have the senior's

mobile number and can call any time", "I have never complained about Caremark but would do if I needed to" and, "I've never had to complain, if I did I'd speak to the manager." One person was unsure how they would complain saying, "I have never been worried about the service. I don't know how to make a complaint if I had one, but I have never been unhappy, so I am okay."

Three people said they had complained in the past and two of them were happy with how the complaint was managed. One person said, "Last year, I started getting calls from new staff who I didn't know, they were fine, but they didn't know me like my usual carers. I spoke with the supervisor and they sorted it out for me." However, one person told us, "I made a complaint about the number of different carers and was told the manager would call me back but it never happened." A member of staff said, "I get the odd complaint, usually about call times, I try to explain that not everybody can have a call at the same, but if they want to take it further I feed it back to my FCS (Field Care Supervisor)."

We saw that people's complaints were initially managed by the field care supervisor and escalated to the care coordinators and management team as required. All formal complaints were responded to in writing and the letter provided the details of the local ombudsman if they remained unhappy with how their complaint had been managed.

There were other opportunities for people using the service and their relatives to provide feedback on the quality of care provided by the agency. This included telephone audits, spot checks and in 2015 people were also asked to complete a quality questionnaire. We saw that the responses were mostly positive and the results of the survey were collated. However where issues of poor care had been identified there was no record of how this was followed up. The compliance manager recognised the importance of this and reassured us that all follow up action would be recorded in the 2016 surveys. One person who used the service told us, "I haven't been asked to complete any satisfaction survey but I have been telephoned several times and asked if everything is okay."

The service had received numerous letters of thanks and compliments from the families of people who used the service. The registered manager told us that they shared this information with staff, particularly if they were mentioned in the card / letter of thanks.

Requires Improvement

Is the service well-led?

Our findings

Services such as Caremark that provide health and social care to people are required to inform the CQC of important events that happen in the service. The registered manager had not informed the CQC of all significant events. This meant we could not check that appropriate action had been taken. For example, one care worker had allowed a client to take a credit agreement out in the care worker's name so the care worker could purchase a sofa. The incident was reported to the appropriate safeguarding team and a thorough internal investigation was completed resulting in the staff member receiving a final written warning. However, we found the CQC had not been notified of this incident. We also saw that one person who used the service claimed that some rings had been stolen from their home. This was reported to the police; again, no notification was submitted to the CQC.

This was a breach of Regulation 18 of the Registration Regulations 2009.

The registered provider is required to have a registered manager as a condition of their registration. There was a registered manager in post on the day of this inspection and they had been registered with the Care Quality Commission (CQC) since 2013; this meant the registered provider was meeting the conditions of their registration and that there was a level of consistency for people using the service and for staff.

People we spoke with told us they felt they could approach the management team including the registered manager and the field care supervisors (FCS) with any concerns or issues they may have. Comments from staff included, "I have a good relationship with the manager. I normally email him if I have any issues, I emailed him on a Saturday once and he got straight back to me", "The full management team are great. They are really lovely and approachable" and, "I know who the manager is but I've not spoken to them. The only time I see them is if I go to the office for training. However, I speak to my FSC almost every day, they are great, and if I have any issues then I just give them a call."

In addition to formal supervision and spot checks, patch meetings were held twice a year. This was an opportunity for the staff to meet up with other staff from their region to discuss issues and share ideas on best practice and ways the service could improve the quality of care they deliver. It also provided an opportunity for the management team to share any concerns they may have, introduce new ways of working and reinforce any pertinent issues. Staff received a newsletter which provided them with regular updates regarding terms and conditions, upcoming training and reminders in relation to best practice, for example, the need to follow the medication policy. The provider's website also gave the staff regular updates on a range of topics.

We asked people whether they found the office staff helpful and whether they were able to easily contact them. People we spoke with knew a number of the care coordinators by name and told us they were usually able to speak with who they wanted. Comments included, "[Name of care coordinator] is in charge of rotas so if I have any issues with rotas I speak with her", "I've never had any issues getting through to the office, they are all great, no problems at all" and, "The office staff area all great." However, one person told us, "If you try to get through first thing in the morning it can take forever."

People told us they received a weekly schedule in advance of any calls taking place so they knew which member of staff was attending and at what time. However, one person told us, "I've not had a rota for this week; this happens now and again, I don't know who is coming. It is usually sent by Saturday at the latest rather than with the carers. It causes distress as I don't know who is coming." We discussed this with the compliance manager who explained, "Visit schedules are posted first class on a Friday and therefore should be received by all of our clients by Saturday" and, "We cannot send them out any earlier as we need to confirm with each member of staff that they are available for the calls that they have been allocated."

Most people who received a service told us that staff were usually on time and stayed for the required length of time. However, others told us they did not feel there was enough travel time allocated for staff. Staff told us they were usually provided enough time between calls to ensure they made it to their next call on time. One member of staff told us, "It's quite good; although it can get stressful when you know you are going to be late but you're stuck in traffic. If I think I'm going to be very late then I ring the FCS so they can get in touch with the client and let them know I am on my way." We saw one member of staff had expressed concern about the amount of time they had to travel between calls, stating they felt it was insufficient. As a result, a desk top travel time audit was completed and this calculated the approximate length of time a journey should take. This information was shared with the care coordinators to encourage them to incorporate sufficient travel time into each carer's rota. However, one member of staff told us, "I still receive rotas with zero time allocated for travel, this means I have to try and make the time up by either arriving five minutes earlier than scheduled for my first call or I arrive five minutes late."

We saw that audits were carried out to ensure that the systems in place were effective and that any issues were addressed. These included monthly audits of daily records, medication records, missed calls, staff files, care files, training, complaints and accidents / incidents. This enabled the compliance manager to check that the information recorded was accurate and take appropriate action should they find any discrepancies.

The registered manager told us they tried to ensure that the staff team received recognition when it was deserved. As a reward for providing high quality care, they presented a ' Care support worker' of the month award. A member of staff told us, "My supervisor seems to appreciate my work. I recently won carer of the month. I got £100 and featured on the Facebook page." Any compliments the service received regarding individual care workers were recorded and the care worker receiving the recognition was informed of the praise; it was also published on the Caremark website and Facebook page. Incentives such as these helped staff know their hard work was recognised.

The registered manager was aware that good staff were key to the success of the service and as well as encouraging good staff to stay, they had forged links with local schools to provide younger people preparing to move into the world of work with an insight into the roles, responsibilities, expectations, qualities and skills associated with a career in caring. They had also delivered dementia and dignity presentations to schools to increase awareness of dementia amongst young people. It was hoped that these links would provide a clear pathway for those considering a career in caring to think about working for Caremark in the future, with the aim of addressing a predicted shortage of staff against a backdrop of an ageing population.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. We saw that medication records and daily diary records were periodically returned to the service's head office; this allowed staff to check these records for accuracy and identify any staff training needs. We checked a sample of the medication records and daily diary records. The daily diary records showed that staff recorded the time they arrived at a person's home and the time they left. They also provided a description of the tasks they had carried during their call and whether they had noted any issues or concerns.