Carewatch Care Services Limited

Carewatch (Dereham)

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

This was an announced inspection that took place on 13 and 15 December 2017.

At our last inspection in April 2017, we found that the quality and safety of the care being provided to people required improvement. We identified that the provider was in breach of five regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because they had not employed enough staff to meet people's needs and preferences, risks to people's safety had not been sufficiently assessed or managed and people's care had not been planned or delivered to meet their individual preferences. Furthermore, not all people's complaints or concerns had been identified and therefore investigated and the provider's governance systems were not effective at improving the quality of care people received or driving the required improvement.

Following that inspection we sent the provider a warning notice telling them they had to ensure they had adequate governance processes in place to drive the necessary improvements required by 30 June 2017. The provider wrote to us and requested we extend this deadline which we did to the 30 August 2017.

At this inspection, we found that some improvements had been made and that the warning notice had been partially met. However, from the feedback we received from people using the service, staff and the records we looked at we have judged that the provider remains in breach of these five regulations. You can see what action we have told the provider to take at the back of our report.

This is the third consecutive inspection that the service has been rated Requires Improvement. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

The overall rating for this service is 'Requires improvement'. However, we are placing 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, 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 over 280 people.

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.

There continued to be insufficient staff to meet some people's needs and preferences. Some staff did not always receive sufficient travel time between calls which made them late attending people's calls. People's care needs and some of their preferences had been assessed. However, not all care had been planned and delivered to meet these needs and preferences which impacted on their daily lives.

The systems in place to monitor that people received their medicines correctly were not robust and therefore, the provider could not be assured that people received them when they needed them.

Once again, some people's complaints or concerns had not been recorded and therefore not investigated to enable the provider to take action to improve the quality of care they received.

The provider's governance systems to assess and monitor the quality of care provided were not all effective. Although we saw improvements in some areas, the provider had failed to take sufficient action to drive the necessary level of improvement required.

At the start of the inspection visit, we found that some people's care records and risk assessments did not have sufficient information in them to guide staff on how to provide people with safe care. However, this was corrected during the inspection therefore reducing the risk of people receiving inappropriate care.

Improvements had been made to ensure that most people were visited by the same staff so they could build trusting relationships with them. The staff that visited people were kind, caring and compassionate. They treated people with dignity and respect and tried to help them be as independent as they could. However, the provider had not ensured that people's care had always been planned and delivered in a caring manner and further improvements are therefore required within this area.

Improvements had also been made to staff training. Staff had received sufficient induction, training and supervision. Where necessary, the service supported people to eat and drink sufficient amounts for their needs although care visits had not always been spaced sufficiently to meet some people's individual needs.

Staff worked well with other professionals and organisations to support with their healthcare and other needs when required. Staff used appropriate techniques to prevent the spread of infection.

People's consent was sought in line with the relevant legislation and information was provided to people in a number of different formats when required to help them make decisions about their care. People had been involved in making most decisions about their care. However, not all of these had always been respected or adhered to in line with people's wishes.

There were systems in place to protect people from the risk of abuse and any incidents, accidents or safeguarding concerns had been thoroughly investigated and learnt from to try to prevent them from re-occurring.

Strategies were being formulated to involve people in the running of the service that included a regular forum that people could attend. Plans were in place to involve people in the recruitment and training of staff and in the development of policies and procedures.

The manager and staff worked well with other services to embed strategies to improve people's health and wellbeing such as in the areas of oral and foot health and to reduce the number of falls that people had. This work was on-going and the manager was keen to collaborate with further organisations for the benefit of people using the service.

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 consistently safe.

There were not enough staff to meet all people's needs.

Risks to some people's safety had not been assessed effectively and staff did not always have access to accurate information about people's needs to enable them to mitigate any risks to their safety. However, for the risk assessments we looked at this was corrected during our inspection visit. The manager told us shortly after the inspection visit, that all other people's risk assessments had been reviewed and updated to contain correct information.

People's medicines were not being managed safely.

Incidents, accidents or safeguarding concerns had been reported, recorded and investigated appropriately to reduce the risk of them re-occurring. Regular analysis of these took place to help the service learn from them.

Staff were aware of how to protect people from the risk of abuse and were confident to raise concerns if they felt necessary and staff were aware of how to protect people from the risk of infection.

Is the service effective?

Requires Improvement

The service was not consistently effective.

People's needs had been assessed along with some of their choices about how they wanted to receive their care. However, not all care had been delivered in line with all relevant legislation.

The manager was aware of best practice and quality standards and had implemented some of these into the running of the service.

People received support to eat and drink where this was part of the care package but improvements need to be made to ensure people's calls are sufficiently spaced to meet people's needs.

Staff had received sufficient training and supervision to provide effective care in most areas.

The staff at the service worked well with other organisations to ensure people received effective care and where needed, supported them with their healthcare needs.

Consent was obtained from people in line with the relevant legislation.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff treated people with kindness and compassion, dignity and respect but the provider had not always planned to deliver people's care in a caring way.

People's diverse communication needs had been assessed and methods were implemented to meet these needs to help people make decisions about their care.

Most people felt involved in their care but further improvements could be made to ensure that people always felt involved in all aspects of decision making.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had been involved in the planning of their care however, not all people's care was being planned and delivered to meet their individual needs and preferences.

People knew how to complain but their complaints and concerns were not always being investigated or dealt with appropriately.

People's wishes at the end of their life were explored and the staff supported people at this time when necessary.

Is the service well-led?

Inadequate

The service was not well led.

The provider had failed to ensure that the governance systems in place were effective at driving improvement within all areas of the service. This resulted in some people continuing to

experience poor quality care.

The provider had a clear strategy in place to deliver high-quality and person-centred care but this had not been fully embedded at this service.

The staff felt there was an open culture at the service where they could report concerns but they felt under pressure and stressed.

The manager was taking steps to involve people in the running of the service.

Carewatch (Dereham)

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.

The inspection took place on 13 and 15 December 2017 and was announced. We gave the service 48 hours notice as we needed to be sure the manager would be available to answer any questions we had. Prior to visiting the office location on the above dates, we obtained feedback from people using the service and some relatives and also some staff by telephone.

The inspection team consisted of three inspectors and two experts 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. One inspector contacted staff over the telephone for their feedback and two inspectors visited the provider's office.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the home, what the service does well and improvements they plan to make. We also reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including unexpected deaths, injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us and additional information we had requested from the local authority quality assurance team.

We gathered the feedback from 27 people who were using the service and seven relatives. We also spoke with ten staff over the telephone whose primary role was to deliver care to people in their own homes. When we visited the office we spoke with two care co-ordinators who scheduled care visits, one quality officer, the manager, deputy manager and the head of quality who represented the provider.

We looked at information in relation to 10 people who received care from the service. We also checked five people's medicines records, three staff recruitment/training files, the provider's training matrix and other

information in relation to how the quality and safety of care was monitored by the manager and provider.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in April 2017, we rated this key question as Requires Improvement. At this inspection we have continued to rate safe as Requires Improvement.

At our last inspection in April 2017, we found that there were not enough staff to meet people's care needs. This had resulted in some people either not receiving their care visits, receiving them at inconsistent times or the staff visiting them late. This resulted in a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014. At this inspection we found that sufficient improvement had not been made and therefore, the provider remained in breach of this regulation.

All of the people and most of the relatives we spoke with told us that staff had attended their care visits when required. One relative said their family member had experienced some missed visits. We spoke to the manager about this. They investigated this and showed us the electronic system used to track when staff had visited people. This showed that staff had completed the visits as required. Therefore, it did not show that any of this relative's family member's calls had been missed.

Although most people were happy they were receiving their call visits, 17 people/relatives told us they were still experiencing either late calls or calls of an inconsistent time that was having an impact on them or their family member. Twenty-nine people/relatives we spoke with did not raise a concern with us regarding the length of time staff stayed with them when completing their care visits. However, five people did, telling us that staff did not always stay for as long as they should and therefore, did not meet all of their needs.

One person told us, "The times are impossible for them as they don't have travel time. It is a bugbear of mine. It's physically impossible for them to be in two places at once. There seems to be no organisation, they are here and there all the time. It makes no sense and must be a fortune in petrol." Another person said, "Yesterday I had my breakfast about 9.00am. Then the next carer came in at 11:15am to give me lunch. I was shocked. It feels horrible. They know I'm diabetic yet they still mess with the times I get my meals." The person went on to tell us that this worried and upset them as they were concerned they could experience hypoglycaemia (low levels of blood sugar) if they went without food for too long. They added, "This did happen once but thank goodness it was my most regular carer who came as they called the doctor. Also, sometimes I feel rushed in the mornings as they arrive late and leave early. It should be 45 minutes in the mornings, but carers often cut this by up to 10 minutes. As soon as I've had breakfast, they're ready to go."

A further person said, "The time they're meant to stay is 45 minutes in the morning but they often only stay 30 minutes. They rush me which makes me cross." Another person commented, "No, there aren't enough staff. If somebody is away, another girl has to cover her calls. The knock on effect is that they can't manage all that and we get late carers. They are in a rush all the time which worries me." Another person told us, "I'm not sure if there are enough staff. They are mostly on time but often the office phone and tell me the staff have to go to another job instead of me. This upsets me and makes me feel neglected. When they do this they can be between 45 minutes and an hour and a half late. I put up with it. There is nothing I can do about it but it upsets me."

Another person said, "Regarding staying the full length of time, as far as I know it is 30 minutes. They knock, sign in, come to me, have a chat, get me into bed and go." When we checked this person's records for July/early August 2017 which was the only one that was made available to us, this showed staff were regularly cutting this person's calls short. Of the 19 calls completed, 16 were under thirty minutes with 14 being recorded as only lasting for 15 minutes or less.

A relative said, "The time keeping is shocking. Staff are often delayed and that can be an issue for my mother who has time limiting needs. My mother has a stoma and catheter, the bags get full and this can lead to problems down the line." Another relative said, "The timings are a bit difficult as we couldn't get a decent slot. It should be 9.00am to 9.30am but it is getting later and later. In fact, it has been too late for breakfast and I found mum and dad haven't eaten when I have got there later as they have been waiting for the carers to come. It is early days though. The times were given to us and I'm hoping that eventually we can get better ones. I think they also have staff shortages." Another person said, "The carers don't always stay as long as they're meant to. They are very rushed and under pressure to go again as quickly as they can so if I don't need them, they go."

During our conversations with these people/relatives, 12 did not quantify how late the staff were getting to them but voiced their dissatisfaction with the service they were receiving. However, five said that their care visits were sometimes at least 30 minutes late with three saying they had experienced calls over an hour late.

The manager disputed that people were receiving care visits that were unreasonably late. They told us that the contract they held with the local authority allowed them to vary the time of arrival by 30 minutes either side of the scheduled care visit and that calls over this time would be deemed as being late. The manager said that only six late calls had occurred out of 80,655 care visits in six months. However, the data provided to us by the manager during the inspection did not reflect this.

When asked, the manager told us they could not provide us with data for the last three months in relation to when the staff had arrived to conduct people's care visits. They said this was because they did not know whether they could run a report off the electronic system regarding this type of data. Therefore, they manually interrogated the system in relation to eight people's morning care visits for the first week in December 2017. This data showed that five of the eight people checked had experienced a care visit that was at least 30 minutes late. Out of a total of the 87 care visits, nine had been over 30 minutes late. These records and people's feedback demonstrated that people had sometimes received calls that were late and outside of the local authority contract requirements.

All of the staff we spoke with told us they had not missed any care visits. One staff member said they felt there was sufficient staff to meet people's needs. However, six staff told us they felt there was a shortage of staff. One staff member told us, "There are not enough staff as they're always asking if we can do overtime. Staff are always phoning in sick and there are not enough mainly at the weekends. We don't get travel time. Calls are back to back. Say if your call is from 7:00am to 7:45am, the next one starts from 7:45am, so you don't get time in between calls. That puts pressure on us because we're rushing to see people." Another staff member said, "Sometimes, staff are a little short. They [in the office] do what they can. I'm not too often asked to cover other calls but I know others are. Other staff are a bit overwhelmed sometimes. I try to stay for the full length of time. You don't get travel time."

Another staff member said, "We're very short staffed so we're trying the best we possibly can. We just need a few more carers. We have no travel time. Things have gone downhill. " A further staff member said, "Travel time is sometimes an issue. For example, if one call finishes at 10.00am and you have to be somewhere else

15 minutes away at 10.00am for another call, that is really hard. You run really late and it builds up. If calls are back and forth, that makes it a bit hard. It would be better if care is better distributed among carers. We're passing carers when we are going for calls. I'll go from one area to another and then pass another carer going to the same area I've just left."

We spoke with the two care co-ordinators about travel time for staff. This is important so that staff can visit people at the times they are scheduled to do so. If this is not done, then a staff member may run further and further behind on their calls. One told us they planned calls including travel time however, some of the staff we spoke with within this area did not agree with this. Another care co-ordinator told us there were enough staff to meet people's needs in their area but they told
us they did not give all staff travel time on certain routes at staff's request.

Based on the evidence gathered during the inspection, we have judged that there were still not enough staff available to be deployed effectively to meet people's needs. This was a continued breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us the service was continually recruiting new staff and had a dedicated recruitment officer to do this. They said they were aware of the issue of staffing levels within one area of the service and had recently recruited more staff who were going through their induction training. They also told us they were aware staff were having to cover a wide geographical area within this patch and were looking at reviewing that so that things could improve. However, the feedback we received from people and relatives covered other areas serviced by the provider and not just the area the manager said they knew was currently short of staff.

At our last inspection in April 2017, we found that the information documented within people's risk assessments was not sufficient to provide staff with the necessary guidance to help mitigate risks to people's safety. This resulted in a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found that improvements had been made within this area. However, people's medicines were not managed safely and therefore the provider remained in breach of this regulation.

We looked to see if five people received their medicines safely. Each person had a risk assessment completed in respect of their medicines to ascertain what level of support they required. However, these were not always clear regarding certain areas of medicines safety. For example, the medicine administration records (MAR) for one person showed that staff were often leaving out certain medicines for the person to take themselves. This was recorded on the risk assessment. However, there was no information within the risk assessment or care record detailing which medicines may need to be left out for the person and under what circumstances. Consideration had also not been given to where the medication should be left, if the person would take the medicine at the correct time or the security of the medicine.

Another person's medicines risk assessment stated they required assistance to administer their medicines but there was no detail regarding the medicines they were taking. This risk assessment was also not up to date as it stated the person did not have an inhaler or liquid medicines but the MAR showed that they did.

We looked at 12 medicine administration records (MAR) for five people and found that then contained gaps where staff had not signed to say they had given some medicines to the person as is required.

For one person, their MAR showed that the number of tablets being given each day exceeded what had been written on the prescription label. We spoke with the manager about this. They contacted the person's GP

and told us the GP had advised that the amount of tablets the staff were giving was correct and that the prescription label was wrong. Therefore they agreed to write a new prescription label. Although we were satisfied the person had received the correct dose of tablets, it was of concern that this error had not been identified and corrected previously as we saw that the incorrect label was on two MARs covering August and September 2017. This placed the person at risk of receiving an incorrect dose of this medicine.

None of these issues had been identified as requiring investigation to ensure that people had received their medicines correctly. The office staff we spoke with told us they were behind with auditing people's MAR as they had been concentrating on updating people's care records and risk assessments.

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

Following our findings, the manager immediately put a new process in place to strengthen the monitoring of people's medicines. This involved senior staff checking people's MARs on a weekly basis and the manager confirmed that all MARs would be audited with appropriate action taken by the end of the year.

All of the staff we spoke with said they had received training in medicines management. They also told us they had had their competency assessed to ensure they gave them to people safely. However, due to the issues we found with medicines management, the provider could not be assured that all staff were sufficiently competent to give people their medicines safely.

We received mixed feedback from staff regarding the level of information that was available to them when providing care to people. Some staff said they always had sufficient information when they visited people they did not know but others said they did not. One staff member told us, "A lot of the people weren't happy when I asked them how they wanted me to care for them because they felt like I didn't know what I was meant to be doing. One of the service users was diabetic and I didn't know that about him until I asked him if he wanted sugar in his tea. That wasn't on the mobile app or book (care record) and that's quite dangerous. I let them in the office know about it."

Another staff member said, "The quality officer does the care plans. They're not always in date. When something changes, the carers let the office know and then I expect them to go to the person's house to review and update the risk assessment and care plan but it doesn't always happen." A further staff member said, "This is a bit of a bugbear with me. I've been waiting for care plans to be put back in the folder and I'm still waiting. I've been waiting at least three months but every time you ring the office, there seems to be a different person who answers the call."

We saw that the information staff were required to gather about the risks to people's safety at their initial assessment was comprehensive and this covered a number of different areas. However, records showed that not all risks to people's safety had been adequately assessed and where they had, accurate and sufficient information was not always in place to tell staff what they needed to do to mitigate such risks.

Three of the people whose care we tracked were diabetic and were required to take insulin to help them manage this condition. They all told us that it was very important they received their care visits at a specific time to manage any risks associated with this condition. However, we found that for all of these people, the risks associated with this condition had not been assessed.

For another person, they had a risk assessment in place in relation to their general and physical health. However, this stated the person had no risks within this area even though the person had a pace maker, left

sided paralysis and sensory loss following a stroke. In addition, there was no information within the person's moving and handling risk assessment to guide staff on how they needed to support this person to move safely taking into account these physical conditions. Also, it had been recorded this person required staff assistance with a catheter but no care plan or risk assessment in relation to this need had been completed. A care co-ordinator confirmed that the person's details needed to be updated.

One person's care plan in relation to their mobility stated the person used a hoist or walked with a frame. It was recorded that they could sometimes walk but sometimes needed the hoist. However, the moving and handling risk assessment did not provide staff with any details of how to use this hoist safely. Furthermore, there was no information about what factors staff would need to consider in relation to the person's safety, when making a decision to support the person to walk rather than using the hoist.

Staff supported this person with catheter and stoma care. However, there was no risk assessment in place or plans of care regarding these areas to guide staff on what they had to do to support the person with these needs safely. For example, if the catheter was not draining correctly or blood was spotted within the person's urine.

We spoke with the manager about these issues. They told us that since the last inspection, a total of 320 care records and risk assessments had been reviewed with people. However, 32 still required updating with the relevant information about people's needs and how to manage risks to their safety. Therefore, some important information was still not available to staff. All of the care records we identified issues with on the first day of our inspection visit had been amended and updated by the second day. The manager told us shortly after the inspection visit that all care plans and risk assessments had been reviewed and that the correct information was now available to staff.

Two relatives we gathered feedback from told us there was no care record in their home to guide staff on how to provide care to their family member. We discussed this with the manager. They told us this was incorrect and that a basic care record was in place at the time of our telephone call to these relatives. They confirmed that a full assessment of these people's needs and risk assessments had recently taken place. We saw one of these care records and found that the risk assessments and associated care plans were clear and detailed to help staff provide these people with safe care.

We looked at three staff recruitment files. The service had completed a number of checks prior to the staff member working to ensure they were safe to work in care. These included the verification of staff identity, a Disclosure and Barring Service (DBS) check and also in relation to their health. However, two staff did not have a full employment history recorded and all three did not have two references on file as required by the provider. The manager told us that this required information had been obtained by the previous recruitment officer but that they had left the service. On the first day of our inspection visit we asked for evidence these areas had been explored. We received copies of references for one member of staff but no other information. Therefore improvements are required to ensure staff have received all of the appropriate checks before they start working for the service.

We received mixed feedback from people regarding whether staff took precautions to reduce the spread of infection whilst providing them with care. Seven people said staff always did this. One person told us, "They always wear their uniform and gloves and aprons." Another person said, "They wear aprons and gloves all the time." However another person said, "None have ever worn aprons but they have worn gloves but they don't wear them all the time." Another person said, "They wear gloves but not always aprons."

The staff we spoke with about this subject understood what they needed to do to reduce the spread of

infection. They told us they always wore protective equipment when necessary and also washed their hands regularly. The provider's training matrix showed that staff had received training in this area and the staff records we checked demonstrated staff competence in this area had been regularly assessed. We were therefore satisfied that staff understood what precautions they needed to take in relation to infection control.

The majority of people and relatives we spoke with told us they/their family member felt safe when the staff were in their home providing them with care. One person told us, "They are supporting me to stay in my home. They keep me safe. They also make sure I am wearing my 'life line'. They always lock up when they leave." Another person told us that they 'absolutely' felt safe with the staff. They said, "They don't threaten me. I trust them not to do anything nasty to me." A further person told us that they 'definitely felt safe' because all of the staff were '100% lovely.'

The service user guide that people received when they started to use the service contained details about abuse, explaining what it was and how they could report concerns. This was to enhance people's knowledge on the subject and sign post them to various organisations to report concerns if they needed to. People and relatives told us they knew how to raise concerns if they felt unsafe. They all told us they would contact the office or the manager if they felt unsafe at any time.

All of the staff we spoke with had a good understanding of how to reduce the risk of people experiencing abuse. They were clear about the different types of abuse that people could experience and we saw that staff had received training within this area. They were also clear about how to 'blow the whistle' if they needed to and said they would have no hesitation to report their concerns to outside agencies such as CQC or the local authority if they felt that was appropriate.

Staff told us they knew they had to report any concerns about possible abuse or any incidents or accidents to their supervisor. One staff member told us how they had been concerned that a person was trying to climb over their bed rails. This had been reported to the office and arrangements made for a physiotherapist to visit the person to ensure it was safe for them to have the bed rails. Records showed that the manager had investigated any incidents or safeguarding concerns appropriately to ensure that people were safe. They had analysed them regularly to see if any lessons across the service could be implemented to improve the quality of care people received across the service. The manager told us there had been no themes identified by this analysis to no changes to care provision had been made.

The manager told us they had recently attended a training session run by the provider that had been conducted in response to findings from CQC inspections. They said they were currently analysing the information from this training session to see how they could apply the findings to this service.

Requires Improvement

Is the service effective?

Our findings

At our last inspection we rated effective as Requires Improvement. At this inspection, we have continued to rate effective as Requires Improvement.

People's care needs had been assessed and included a number of different areas that included their physical, mental and social needs. People's diverse needs had also been fully assessed as had some people's preferences and choices. This included their preferred name, method of communication, some likes and dislikes and what was important to them. We had mixed views from people as to whether other preferences such as the times of their call visits and the gender of the carer they wanted visiting them had been adequately assessed. Also, although these needs and some preferences had been assessed, the care had not always been delivered to meet all people's needs and choices and not in line with all relevant legislation.

The manager told us they were aware of best practice guidance such as that outlined by NICE (The National Institute for Health and Care Excellence). They also said they regularly reviewed information from Skills for Care and the Social Care Institute for Excellence. From this best practice, they had identified that there was an issue with oral health within the community. Therefore, they were doing a promotion within the local area in relation to this issue. A senior member of staff had been involved and people had been sign posted if required, for dental treatment. Plans were in place to conduct a similar promotion in respect of foot health.

At our last inspection in April 2017, we received mixed feedback from people regarding whether staff had sufficient knowledge and skills to provide them with effective care. At this inspection we again found that feedback was mixed. People were happy their regular carers had received sufficient training. Twenty-eight people/relatives did not raise any concerns with us regarding the staff's skills or training. However, six people/relatives did and they told us they felt that those who visited them less frequently were not so well trained. They said this was because these staff did not always know what needed to be done to support them effectively.

One person told us, "They know how to support me." A further person said, "They are trained very well because they always know exactly what to do." However, another person said "The regular carers are better trained than others. The very young ones are not as good as they could be. They are friendly but rush in and out as fast as they can. They are not practical at all for example, they don't know how to fold a towel and hang it on my rail." Another person told us, "My regular carers are good but I don't think all the younger carers have been fully trained, yet they're expected to do the same as the older (experienced) ones." A further person said, "Some of them don't always know how to do things. I have to tell them, show them. My more regular carers are sensible and know though what to do."

We also received mixed feedback from relatives. One relative told us, "My wife has a PEG feed (Percutaneous endoscopic gastrostomy which is a tube passed into the stomach in which food is administered) and the staff know about it. The district nurse tells me they look after the tube site very well and keep everything clean. My wife is nursed mainly in bed although we do have a hoist only a couple of staff use. I will do it with

them. I would say they are quite well trained. I am confident in the staff we have now." However, another relative told us, "They make a sandwich for him but if it isn't his regular carer I have to keep a watch on the dates. Some of the staff don't think to use things in date order and sometimes I have had to throw food out. I even slice the tomatoes and things as they don't think to do this even."

All of the staff we spoke with told us they had completed the provider's mandatory training. This provided them with knowledge in areas such as, but not limited to: dementia, safeguarding adults, food hygiene, moving and handling and infection control. The provider had a regional trainer who provided staff with training and some staff told us they were able to do extra training to help support people they provided care for. For example one staff member said they had received training in catheter care. However, they added they would like to have further training in diabetes management. We saw the manager had recognised this and was planning for staff to have training in this area.

The provider had a training matrix in place that detailed all of the mandatory training staff had completed. We saw from this that the staff who were required to complete this training had done this in line with the provider's requirements. We checked two staff member's files for evidence of training in respect of catheter and stoma care which was noted as a requirement by the local authority who had commissioned the care for a person. There was no documented evidence to show these staff had completed this training. We spoke to the manager about this. They told us the two staff had completed this training but that the record of their training had been omitted from their files in error.

Staff told us when they started working for Carewatch Dereham that they had completed a comprehensive induction programme and shadowed a more experienced member of staff. This was so they could gain confidence and skills to perform their role effectively. Records showed that during this time, staff received regular supervision and support. They were only allowed to work with people independently when either the manager or a senior member of staff was satisfied they had attained the relevant skills to do so safely. Records also showed and staff told us, their competence to perform their role had been regularly assessed to ensure they were sufficiently skilled to work with people.

Most of the people we spoke with did not have support from the service to prepare their food and drink. However, where they did people were satisfied with how their meals were prepared and that they had choice about what to eat. One person told us, "I tell them what I want and then they help me to get it. They always make me a cup of tea too. I am very happy with this arrangement." Another person said, "I have had my carer for a long time and she knows what I like she will cook for me. They are lovely meals". A further person said, "They put my breakfast out for me. I am happy with this and always choose what I want myself. They also make me a drink before they go as well."

However, three people we spoke with who were diabetic told us their meals were not always prepared in a timely way to help them manage this condition. One person said, "They do try to come on time, but I know they get held up. I am diabetic and need regular meals, so I can have my injection."

All of the staff we spoke with had an awareness of the importance to ensure people had enough to eat and drink. This was even if they were not providing assistance in this area. One staff member told us how they had raised a concern because a person they visited was regularly saying they were hungry and that this was being investigated. The manager told us where there were concerns, staff regularly monitored people's eating and drinking and reported issues if necessary. The quality officer told us that weekly weight charts were soon to be introduced to help with the monitoring of people's food intake where this was appropriate.

The care records we looked at on the first day of our inspection where the service was supporting people

with eating and drinking did not contain information about people's food likes or dislikes or how they liked their food to be prepared. However, on the second day of our inspection visit these care plans had been updated and contained this information. The manager told us this type of information had been captured from people and was currently being transferred into their care records.

Most of the people we spoke with arranged their own healthcare. However, they told us they felt confident that staff would support them with this if required. One person told us, "'If I'm not well when a carer comes and they think I need a doctor, they do ring one for me which pleases me." Another person said, "I usually do this myself but if I am unwell then they will contact the doctor for me."

All of the staff we spoke with had a good understanding of which healthcare professionals required to be involved to support people when needed. Records showed and staff told us that they reported concerns to various professionals such as the person's GP or district nurse if needed. We saw that staff had contacted emergency services when required. One office based staff member told us how the service had started to signpost people to other services that could help them with a specific condition. For example, contact details for organisations who specialised in conditions such as Parkinson's disease or Multiple Sclerosis. The staff member said they had obtained good feedback from people about having this type of information available to them.

The service worked closely with outside organisations such as the local authority when arranging to provide care to people. Regular dialogue was held with professionals such as social workers, occupational therapists and GPs to ensure people had the correct package of care, equipment or medicines/healthcare to meet their needs. The manager told us that recently a new system had been implemented by the local authority when referring people to them for care. They said this was causing some concern as the relevant paperwork to enable them to commence a care package was being delayed. However, they said they were in regular communication with the local authority about this to ensure this was not having a detrimental impact on people who may have been waiting for care from the service.

The people and relatives we spoke with did not raise any concerns in relation to consent. They said this was always sought prior to any care being provided. One person told us, "'They do check everything with me." Another person said, "'They always ask me if they can begin." A further person told us, "They always ask me first."

The manager told us that most people using the service had capacity to make decisions about their care. However, they had ensured that where people lacked capacity, the staff had sufficient knowledge in this area to ensure they sought consent within the relevant legislation. All of the staff we spoke with were aware of the Mental Capacity Act 2005 and its principles. The 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.

Staff were able to demonstrate to us they understood the importance of this legislation and how to support people to make decisions if needed by offering them choice. One staff member told us, "I give them choices. You sort of suggest to them so that they can make a choice." Another said, "We need to be able to support people to make their own decisions. I help them to make decisions by offering them choices."

Care records showed that an assessment of people's capacity was conducted where necessary. If people did require any support to make decisions, there was information available to staff to guide them on how they

could do this to support the person. We were therefore satisfied that consent was obtained from people in line with the relevant legislation.

Requires Improvement

Is the service caring?

Our findings

At our last inspection we rated caring as Requires Improvement. At this inspection, we have continued to rate caring as Requires Improvement.

The people and relatives we spoke with told us the staff that visited them in their homes were kind and caring and treated them with dignity and respect. However, the provider had not ensured that some people's care was consistently planned in a caring way. Some people told us they received care at inconsistent times or that their care calls were late. We were concerned that others told us that male carers were being sent to them to provide care when they had requested this did not happen which may have compromised these people's dignity.

Most people and relatives we spoke with told us that they now usually saw regular care staff and that this area had therefore improved. One person told us, "I have been getting the same (staff) lately but at first there were too many. I am a very private person and I found it all very embarrassing. Now I have mainly two people who come. They have got to know me, so I don't have to keep going through it all. I have a lot of pain and need them to work with me." Another person said, "Ninety percent of the time I have my regular carer, we have got to know one another well." A further person said, "For the last two to three months I have had more regular carers. It's better." One other person said, "Most of the time I have the same carer, she is absolutely brilliant. A bit like a daughter really."

People and relatives we spoke with were very complimentary about their regular staff. They told us they felt these staff knew them well and that they treated them with kindness and compassion. We received some very good feedback about people's regular carers.

One person told us, "The girls are lovely they are almost friends. In fact, one of them invited me to her wedding. Another member of staff hadn't been for a while and when she came she bought me some roses, so thoughtful. They all chat to you and we have got to know each other." Another person said, "The carers are all very good. My regular carer is very caring and even changed a light bulb for me and when my bedside lamp broke, the carer got another lamp for me." A further person said, "The carers go out of their way to do things for me, like warming my underclothes on the radiator, I can't fault them."

A relative told us, "I can hear the staff laughing and joking with my wife when they are carrying out personal care they are very good with her. They know my wife and will tell me if there is anything they think I should be aware of." Another relative said, "The staff are very good, and mum trusts them. I think they are getting to know her. They are very good at putting mum at ease. Dad thinks they are marvellous, they are forming a relationship with them both." Another relative said, "On the whole the staff are very good."

Most people told us they felt involved in making decisions about their care although some said the service could improve this by ensuring they were involved in decisions about the timings of their call visits. People said that the staff that visited them involved them in making day to day decisions about their care by offering them choice. One person told us, "Staff listen to me, we talk about all sorts." Another person said, "I

feel in control of my care. The service review it about once a month which is very pleasing, I feel involved, I just sit there and let them get on with it which I am very happy with." A further person told us, "It helps me a lot having her around. She does listen to me and I feel very confident talking to her about anything." However, another person said "I've had my say. I feel in control of my care but I said what time I wanted them to come and the fact they don't is another matter. They do all the changes themselves without asking me. I'm not comfortable with that, it worries me." Another person said, "Sometimes I (feel in control of care). I think it's them (agency) that make the decisions about time and that, but overall I feel involved."

People had the opportunity to be involved in making decisions about their care when they started using the service and at reviews of their care. These were held regularly either via the telephone or face to face. The latest performance measures from the provider showed that 98% of people had received a face to face review within the last 12 months and 94% one within the last six months.

People's communication needs had been fully assessed and there was sufficient information available to guide staff on how they needed to communicate to people. The manager told us that the documentation they used to help people make decisions about their care could be provided in different formats if necessary such as braille. Other forms of communication such as interpreters were available if needed. The service was meeting the Accessible Information Standard. This standard has been in place since 2012 and requires providers of publically funded services to have facilities in place to meet people's diverse communication needs.

Most people and their relatives told us that staff treated them with dignity and respect and encouraged them to be as independent as they could be. They also said they felt in the main, that staff were polite and professional. One person said, "The carers are smartly dressed, clean and polite. They respect me and treat me well. They always put the quilt down further to cover me (during personal care). They do encourage me to do things and we have a routine now." Another person said, "They are pleasant and friendly and they treat me with respect. They always shut the door and draw the curtains when giving care and make sure I am happy with what is happening. They encourage me to walk to the bathroom and out again." A relative told us, "The staff are very good though with him. They are polite, and he seems very happy. I know he would tell me if he wasn't." We saw there was some good information in people's care records advising staff on how they were to support them to remain independent.

All of the staff we spoke with demonstrated they had a caring attitude towards people and valued their relationships with them. They knew people they regularly supported well. We saw they had access to information such as a person's life history that had been gathered when they started using the service. This helped staff have meaningful conversations with people to build relationships with them.

All staff understood the importance of treating people with dignity and respect and ensuring they were not discriminated against. Staff had received training in this area and also in equality and diversity so they could ensure they had an awareness of people's diverse needs. Staff told us they encouraged people to be as independent as they could be by, for example, encouraging them to provide their own personal care where they could or walking regularly.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection we rated responsive as Requires Improvement. At this inspection we have continued to rate responsive as Requires Improvement.

At our last inspection in April 2017, we found that care had not always been planned or delivered to meet people's individual needs or preferences. This had resulted in a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the necessary improvements had not been made and therefore, the provider continued to be in breach of this regulation.

When people started to use the service, they were visited by a staff member who conducted an assessment of their needs. Most people and relatives we spoke with told us this had happened and that they were able to tell staff how they wanted their care delivered to them. We could see from the care records that the staff who conducted these assessments, asked people/relatives a number of different questions about the care they needed. The office staff we spoke with said they also asked people their preferences such as their preferred method of communication, name, call times and gender of carer to visit them. They said it was not always possible to meet people's preferences in relation to call times at the start of the care package, but that they would try to do this as soon as they were able.

A number of people/relatives we spoke with told us that the care they received met their individual needs and preferences most of the time when they received care from their regular carers. One person told us, "I have got regular carers, but it is difficult when they are off. They seem to know what they are doing." A relative told us, "I am very happy my wife is getting the care she needs." Another relative said, "I think they do know him well and know how to support him in the mornings to make his bed and wash up at lunch times."

However, 17 people/relatives told us that on occasions, the care visits were late or were not consistently planned to meet their needs and preferences and therefore, did not provide individualised care. One person told us, "I like to get up and ready for them. Although I am happy to get up early, as I would prefer an early call, I don't want to be getting up at 5.30am as I do for the ones that come at 6.00am when they don't arrive until gone 7.00am. I may as well have stayed in bed. The weekends are the worst you just never know who is coming." We looked at this person's scheduled morning calls from 1 to 12 December 2017. This showed that all four daily morning calls that had been scheduled over this time were at different times being 6.15am, 6.30am. 7.30am and 8.15am.

Another person told us, "My regular carer arrives on time and is very good. My regular time is around 7:30pm to 7:45pm. However, when my regular carer is off the fill in carers come at 5:30pm or 5:45pm which is too early." They went on to tell us this made them feel angry and disappointed. A further person told us, "They can be an hour late. This last happened a couple of weeks ago and no-one let me know. I ring the office to find out where the carers are or if they're coming at all. They usually show up but I worry if I don't know what's happening. My regular carer arrives at 9.00am sharp, whereas others change the time according to their needs. The others overlook what I want. I just have to sit and read my book and wait."

One person told us, "I used to go to bed at 11.00pm. It's a different time every night that they come. The earliest was 6:15pm. I was pretty annoyed. The average tends to be 7.00pm, but one carer is always 8:30pm." We looked at this person's records. Their care calls had been requested to be completed by the local authority after 8.00pm each night but the service had recorded 8.00pm as their preferred time. When we checked the person's communication log book for July 2017 that staff updated when they provided the care visit, we saw that 13 of the 18 calls had been completed prior to this time. The five other calls had been completed between 9.05pm and 9.46pm.

Another person told us that when there were any changes of carers this frightened them if they were not told. In this person's file we found a comprehensive assessment of the person's needs had been completed by the local authority. This had stated the person experienced high levels of anxiety and received support from specialist mental health providers. However, none of this information was in the care record completed by the provider. There was no record on their file to ensure that the person was contacted to tell them of staff changes to alleviate any anxiety they may feel.

Three of the people we spoke with who told us they required to take insulin to control their diabetes, said that they had experienced inconsistent and late calls. The care records for these people demonstrated that this aspect of their care had not been planned to meet their individual needs.

We discussed with 14 people/relatives whether they had been asked if they had a preference in relation to the gender of the staff member who provided them with care. Nine people told us they had been asked although three of these said their preference had not been respected. Five people said they had not been given any choice. One person told us, "I was given a choice and this has been respected." A relative told us, "I was asked if I minded a male carer and although at first I said no, one of the men came to speak to me and it put my mind at ease. In fact, he helped set up the new electronic mattress as he had seen them before. I am very happy now."

However, one person told us, "I have requested not to have male carers but they have sent them in the past. I notice there is one due to come this week so I will be contacting them." A further person told us, "I didn't want a male but I think they put me down as not minding. I'd prefer a lady." We checked these people's record and there was no preference recorded on the system in relation to this preference. A further person told us, "No, I wasn't given a choice. I had a male to start with and I took a step back at first because I was shocked. I have help washing so I didn't want a male. It's the way I have to stand half dressed in front of him." We spoke to the manager about this who updated the person's record to indicate their care should be planned with female carers only. A relative said, "Mum was asked if she minded a male carer and she said she would rather not. However, one turned up and I had to request we didn't have him again which they have listened to."

The staff we spoke with told us they were aware that some people were not happy about the timings of their calls and that the calls they had been scheduled to make were sometimes inconsistent or the person had a different time on their schedule to them. One staff member told us, "I had an example last night. They (person) had the timing that the carer was coming at 8.00pm but on my phone, it was 7:15pm. They were still having their dinner when I arrived. I just apologised and said I'll wait till you're ready and that made me run late for my next call." Another staff member said, "Sometimes we question the calls which have been put in different orders. We say we can't do that because that isn't how the client wants it. That's the trouble. For example, one client that we go to at 4.00pm, they sent us to them at 6.00pm. Last night, her husband said, 'this isn't any good." They added, "One gentleman likes to go to bed between 6:30pm and 7.00pm and they put him for 8.00pm call. His son wasn't happy about it. We just do what is best for them."

Another staff member said, "A lot of customers complain about the call times. They could do with a little bit more consistency with the call times rather that a vast range of times when we can turn out. I think things are getting better and they are trying to work with carers not to keep changing call times and to notify the office before the times are changed." A further staff member said, "I have been seeing the same people but I've got one lady whom I've got to see at 7.00pm and she doesn't like it. She prefers 8.00pm to 8:30pm. I don't know why they do that. I think it's a matter of who's available to see her and another staff member said, "They're starting us earlier than they used to. It can now be 6.00am or 6:30am to get people up. I've been at a lady's house at 6:15am to wake her up. I don't think she likes it but she lets it happen because she likes the girls. It's not good because she goes to bed quite late."

The evidence above demonstrates that the provider had continued to fail to plan and deliver care to people based on their individual needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Most people's care had recently been reviewed. However, the new information gathered about people's current needs or preferences had not yet been transferred to these care records. Therefore, staff did not always have access to sufficient and accurate information about people's needs and preferences. There was a lack of clear information to tell staff exactly how people wanted their care provided. For example, one person's care record stated the staff needed to 'wash them on the bed' or 'dress them on the bed' but there was nothing about how the person liked to be positioned and how staff should do this to protect the person's dignity. The person's continence care plan stated 'I wear pads' but there was no other information available.

For another person, their care record had not fully completed in relation to continence care. It stated the person was not independent with continence, but there was no further detail or guidance for staff in relation to this. We queried this with a care co-ordinator who said this was an error and that in fact, the person was independent with their continence. They immediately corrected this error.

The manager told us they were in the process of updating people's care records and we saw the new care records. These were much improved and had comprehensive information about people's needs and how they wanted their care to be provided. Shortly after the inspection visit, the manager told us that all people's care records had been updated and were available for staff to view.

At our last inspection in April 2017, we found that people's complaints had not always been dealt with effectively. This resulted in a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the required improvements had not been made and therefore, the provider remained in breach of this regulation.

Everyone we spoke with told us they knew how to make a complaint if they needed to. However, we received mixed views from people and relatives in relation to how well the service dealt with any concerns they raised. Some relatives told us they had raised concerns in the past and that these had been dealt with to their satisfaction. A relative told us, "I do know how to complain and did so at the start as they were turning up too late in the morning and too early at night. It's all sorted out now." Another relative said, "I would speak to the manager I believe her details are in the white book. There is a page in the folder that I can leave messages in which is good. I did leave a comment and it was dealt with. They left I note to say they had seen my comment and would deal with it. This system seems to work well." A further relative said, "I did complain about having a male carer and told them why I didn't want him, and he hasn't been back."

However, seven people said they had raised concerns either with the office or directly to the staff but that

nothing had changed. One person told us about the inconsistent times of their calls, "I have brought it up with the co-ordinator but I don't think they really understand what it's like as they work in the office." Another person said, "This is my one complaint. They send this young man and I'm an old lady. I'm not having a young man washing me. It's like having my grandson doing it. I have complained to them once or twice but they still send him. The last time was last Friday. I told him I wasn't having him in. He understood as he's been there before and knows I don't want a male carer. They tell me they will put it right and that it won't happen again but then they send him again. It makes me angry as I end up not having care on those days as I won't have a male carer." We spoke with the manager about these concerns. The manager was not aware of any of them as they had not been noted on their system for investigation.

Another person said, "We have requested that they change this (times of calls) but nothing happens. I do wonder who the service is run for. The person went on to explain that this made them feel frustrated and angry. They added, "I don't ask for anything unusual, they should be able to make adjustments. They don't respond well to complaints. I have raised an issue regarding the billing from the agency as they are always inaccurate but their response has been to ignore it." A further person said, "I've told the carers when they're too early," They went on to say that they were still experiencing issues with the times of their calls.

Another person said, "I made a complaint about the times of the calls about a year ago. It was sorted for a little while but now it's gone back again. I have rung them before but they don't do much about it, nothing's changed." We spoke to an office staff member about this person. They told us they had received a concern from a third party about the timings of calls in relation to this person's healthcare needs. We were aware of this as we had referred this concern to the local authority after we had made the call to the person. It was encouraging that the issue had now been dealt with however, this was only corrected following the concern we raised following the person's current feedback.

We checked the records of another person who had raised concerns with us about their call times. We saw they had raised this with the provider during an audit they conducted in March 2017, again in August 2017 during a review of their care and again in October 2017 during telephone monitoring conducted by the office staff. However, this continued to be an issue for them.

This was a continued breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The staff we spoke with about complaints told us they knew the provider had a policy regarding complaints and said they had read and understood this. They said they would let the office know if people raised any complaints or concerns with them and would expect them to then deal with it.

Any complaints that the manager had seen had been dealt with appropriately. A full investigation had taken place and the person who raised the complaint contacted.

The manager told us that they did not take on packages of care where people were reaching the end of their life. However, they said that the service was able to do this and that systems were in place to ensure people received compassionate, responsive care in this area. Plans were in place for the deputy manager to complete a specialist accredited course. They would then share their knowledge with staff . Staff were able to access training within this area if they required it.

We saw that as part of the initial assessment when people started to use the service, their wishes in respect of their death were discussed. These had been recorded appropriately in the care records we viewed so that staff could respect people's wishes.

Inadequate

Is the service well-led?

Our findings

At our last inspection we rated well-led as Inadequate. At this inspection we have continued to rate well-led as Inadequate.

At our last inspection in April 2017, we found that the provider's systems and processes were not robust enough to enable them to monitor and drive improvement within the service. This resulted in a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We issued the provider with a warning notice and told them they had to be meeting this regulation by 30 June 2017. This timeframe was extended following a request from the provider to 30 August 2017. The provider also sent us an action plan following our last inspection telling us they would be meeting the other regulations we had found breaches in by 31 August 2017 at the latest.

At the beginning of this inspection, the manager told us they felt that significant improvements had been made since our last inspection. However, although we found there were some improvements, not enough progress had been made and the current systems did not always effectively monitor or drive improvement in relation to the quality of care people received.

People and relatives told us they were very happy with their regular care staff and would whole heartedly recommend the service based on them. Twenty-two of them told us they were happy with most aspects of the care they received although some people said their recommendation was based on the staff rather than the organisation. Some told us they felt that the service was improving. One person told us, "I suppose I would recommend them, but I have nothing to compare it with. I am told all these companies are the same." Another person said, "I would recommend them. I am happy with everything at the moment."

A relative told us, "It has only been a couple of months and they were pretty much thrown in at the deep end but so far we are happy and I would recommend them." Another relative said, "I would recommend although I think the organisation in the office could be improved the staff spend too much time toing and froing". A further relative told us, "I would recommend them at this stage but I do hope I can get earlier times."

However, 12 people/relatives expressed some frustration with how the service was run and its organisation. One person told us, "The office staff don't seem to have any common sense. The routes for the care staff don't seem to be organised. There is a lot of back and forth. For instance, they could be in one village then expected to be in another and back to the first place all in the space of an hour. Then they have to contend with the traffic." Another said, "It has all gone haywire. The office is completely disorganised. Office staff don't really know what it's like out on the street so to speak. The organisation isn't always good. I have been known to have two people turn up when I only have one and they designate people to go places without looking at the map. Disorganised. I would recommend the care staff, but I have reservations of the attributes of the office staff."

A relative told us, "The organisation could be improved, things like the travelling time and routes. I don't

think it's a very organised organisation." Another relative said, "I don't think it is particularly run well because they don't seem to know what to do half of the time. If they can't give you a ring when you've asked them to well that's not being well managed and if they can't give you a carer at a time when you've asked for, it's not well managed."

Fourteen people/relatives voiced their dissatisfaction regarding the schedules they received that told them which staff would be visiting them. They told us these either had unallocated slots or that different staff turned up to what was recorded on their schedule. People and relatives also voiced their frustration at not being told if the scheduled staff changed.

One person told us, "Sometimes I get a list but I know if there is no one allocated there is going to be a problem with the time." Another person said, "We do get sent a weekly programme. However, the names on the list don't match the person who arrives. It's inconsistent. No-one keeps me informed if the carer will be late or tell me how long it might be before a carer arrives. I find this annoying, especially as the carers tell the office but then the office don't tell us, the people that count." Another further person said, "Sometimes the slot is unallocated, and I have no idea who is coming or what time. This can cause an issue as I can't get my food until they come, and I need to eat to take my medication. I ring up when I see it is unallocated as I know there will be a problem, but they will tell me they don't know anything about it."

Another person said, "No, the service don't let me know of any changes. I get a rota it gets changed so nothing matches up with the list they send. I get so frustrated with them. It's such a waste of everyone's time. Sometimes I think they forget that we (client) are the most important people, yet 'we're the last to know what's going on."

Some staff also commented about people being told about changes to care times. One staff member said, "Clients are not very often informed if there will be a late call. They don't always get sent a rota. It depends on who's doing it. It's not always the correct time and the times are different on the phones." Another staff member said, "We used to have service users numbers so that we could ring them to let them know if we are running late but now we're not allowed to have their numbers." A further staff member said, "The client gets a schedule but if someone goes off sick, there is no guarantee but the problem there is that they [the office], don't let people know and I think that's bad."

It was stated in the service user guide that people were given when they started using the service, that if their regular carer was not able to attend their care visit then they would be advised of this and told who would be visiting instead. The head of quality and the manager told us that if any changes occurred to people's care visits that people should be being told. However, the office staff told us they did not have time to do this. Therefore, this required procedure was not always being followed as expected by the manager and provider.

Following our last inspection in April 2017, the manager said the head of quality for the provider had visited them in May and June 2017 and that regular weekly discussions had taken place between them to evaluate any progress made. They confirmed that information was also sent to the provider on a regular basis regarding the quality of care being provided. However, we found that the provider had again, only conducted one full internal audit of the service since our last inspection in April 2017. This had been completed in July 2017. Although the provider had recorded that the compliance score for the service had improved at this audit (this is a score awarded by the provider) from 49% in March 2017 to 69% in July 2017, they had still rated the service as red and of high risk. Even though this was the case, no other internal audit visits had taken place since this date to check that improvements were being made.

During the provider' internal audit in March 2017, they checked ten people's records and identified that eight of them held out of date information. They had recorded that because the paperwork was so out of date they could not judge whether adequate control measures had been identified or that the risk assessments in place contained adequate information. An action plan was put in place for this to be rectified and it was noted the manager had stated this work was due to be completed by May 2017. In the provider's follow up audit conducted in July 2017, they checked eight of the same people's care records and risk assessments. They found repeated issues with six of them. Therefore the actions required had not been completed.

After the inspection visit, the manager sent us a copy of their own internal audit of the service that they conducted in November 2017. The audit stated that all risk assessments had been upgraded following review and where the audit asked, 'are assessments detailed and person centred' the audit had been completed as being 'met'. However, at the time of our inspection visit, we found that although people's needs and risks to their safety had been reviewed, not all care records or risk assessments had been updated to reflect their current needs. Furthermore, not all of this information was available to staff placing people at risk of unsafe and inappropriate care. The manager told us this had been corrected shortly after our inspection visit.

The manager told us there was a document in place to enable them to track when people's MAR had been returned to the office and audited. When we asked the manager when the people's whose MAR we looked at had last been audited they could not tell us. This they said, was because the document they used (called the field document tracker) to track this was not up to date. This had been identified as an issue in both the provider's audits in March and July 2017 but had not improved. Therefore the manager's and provider's overview of what had been audited was not effective to ensure that people were receiving their medicines correctly.

The manager told us that all staff should be checking people's MAR on each visit to ensure people had received their medicines correctly. However, there were no records that some of the gaps we had identified had been picked up as an error by the staff visiting people and reported to the office for investigation. Therefore this system was not working effectively. Also, when we spoke to a quality officer about the auditing of MAR they told us that only 10% were required to be looked at each month. However, the manager told us that 100% should be reviewed. This demonstrated a breakdown in communication.

A central spread-sheet was in place where any medicine errors made were recorded. We saw that this enabled the manager to keep a track of which staff required re-training or reminders about safe medicines management. Actions had been taken where appropriate. However, as the medicine audits were behind, timely action had not been taken to ensure staff were following the correct procedures.

It was stated on the audit completed by the manager in November 2017 that all medicines administration records (MAR) were returned to the office from people's homes each month and that 100% had been audited. If the MAR were collected and audited monthly as stated then at least five of the 12 MAR we looked at which were dated September 2017 or before, should have been audited but only two had been, both of which had not identified and therefore investigated, the discrepancies we found. Therefore the conclusion of this audit was incorrect.

In respect of checks on staff prior to them starting work at the service, the manager's audit which followed the provider's template, did not assess whether gaps in staff's previous employment history had been explored which is a requirement of the regulations. We found issues within this area.

In their action plan following the last inspection, the provider told us they would monitor safe levels of care

hours to head count. The manager told us this was achieved through a combination of methods including customer feedback, staff holidays, planning for peaks and troughs, growth and by applying a calculation of 21.5 hours per carer. However, we continued to find issues in this area and therefore the current systems in place to monitor that there were sufficient staff and that they were deployed effectively were not robust.

Following the our last inspection in April 2017, the provider told us in their action plan that they had captured people's preferred call times and rescheduled calls to meet these as much as possible. However, people still told us this was an issue and that they received some inconsistent calls. The ongoing monitoring of this had therefore not been robust.

After our last inspection, the provider told us that all complaints were logged onto a central system for investigation and analysis. However, a number of concerns people raised with us during this inspection has not been recorded. This was despite people telling us they had raised them with staff in their home or with the office. This implied that staff may not have been reporting or recording all complaints as deemed necessary by the provider. In August 2017, 60% had told the provider in their monthly customer survey that they were not happy that their concerns had been sufficiently addressed. Three months later we found the same issues. This indicated that any action the provider had taken to investigate this had not been robust.

We asked the manager how they monitored for late or missed calls. The manager told us that an electronic system had been in place since July 2017 to do this. They said that an alert would be raised after 15 minutes of the allocated call visit time. They said that as soon as an alert occurred, staff would interrogate this and if necessary advise the person why the staff member was not with them. The office staff we spoke with confirmed this.

We therefore asked the manager for data on how many system alerts had been produced in the last three months. The manager did not supply us with this data. This they said, was because all system alerts were immediately shut down once they had been dealt with and that no record was kept. They did however tell us that any concerns regarding missed or late calls were recorded on another internal system. The manager told us that only six out of 80,655 calls that had been made over the last six months had been late (over 30 minutes). However, the data provided to us during the inspection for eight people's morning calls for one week in December 2017 showed that nine of these people's calls (five effected) had been over 30 minutes late within this small timeframe. Therefore we have concluded that the data on the provider's systems in relation to this matter were inaccurate as the systems in place to monitor for late calls were not effective.

The above evidence demonstrated an on-going breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The head of quality told us there was a clear strategy in place to deliver high quality care and to promote a person-centred culture and said that the provider's focus going forward was on quality. However, we found this strategy had not been fully implemented at this service and that therefore, improvements were required to fully embed this philosophy.

Where asked, most staff told us they felt supported and valued in their role but some said they felt stressed and under pressure to complete care visits. They gave us mixed views regarding whether they felt the service was well-led. However, they did all say that they felt confident to report or raise concerns if they felt they needed to and were not afraid to do this which demonstrated an open culture. They all said that in their experience, actions had always been taken in response to anything they had raised.

The manager told us they were involving people in the running of the service. To do this, they had sent up a

forum which had occurred in August 2017 and attended by five people. Here, people had been asked for their ideas on the running of the service. Following this the manager told us that a 'service user' participation group' had been set up for people to be involved in shaping the service in the future. Plans were in place for people who used the service to be involved in the recruitment of staff, staff training and developing policies and procedures.

The provider surveyed 20% of people using the service each month. We saw the surveys for August, September and December 2017. Few people had participated in these surveys (13 in August, two in September and three in December 2017). This made it difficult for the provider to obtain sufficient views regarding the overall quality of care being received although the manager told us they had addressed each person's individual concerns where they had been raised.

Community links were in place and the manager was keen to develop these further for the benefit of the people using the service. For example, staff had taken some people who used the service who were living with dementia to the local theatre to see a show specifically designed for people living with this condition. Other staff regularly took people out into the community to enjoy activities such as high tea or shopping.

They also told us that the provider's recruitment strategy had changed. They said that any questions and assessment of potential staff was under taken taking into account the provider's values. This meant they only recruited staff who demonstrated these values. Also, the manager said that assessments of people's needs were to be more focused on their strengths and based on outcomes to enhance their wellbeing.

The manager worked well other with organisations and was looking to embed strategies into the staff's daily work to improve people's wellbeing. For example, they were working closely with a local falls team to improve the risk of people falling. They were also working with another organisation to promote oral health and plans were in place to do this for foot health. A strategy was also being formulated with the local authority so that joint assessments of people's needs were conducted by staff at the service and social workers. The manager told us the aim of this was to ensure that all relevant people were involved in the assessment to make it a more seamless service for people.