Carewatch Care Services Limited

Carewatch (Isle of Wight)

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?	**Good**
Is the service responsive?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

Carewatch (Isle of Wight) provides domiciliary care services to people living at home. They currently provide a total of 2005 hours of personal care to 170 people. Each person received a variety of care hours from the agency, depending on their level of need.

The inspection was conducted between 20 and 27 April 2017 and was announced. We gave the provider 48 hours' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.

There was a registered manager in place. 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.

Staff did not always have access to adequate guidance to help ensure individual risks to one person were managed appropriately. However, people told us staff knew how to protect them from harm and staff took action to keep people safe.

Where people required assistance to take their medicines, these were usually managed and administered appropriately. However, there was a lack of information to support staff to administer one person's 'as required' medicines safely.

Senior staff responsible for planning people's care did not always follow legislation designed to protect people's rights, although care staff did seek verbal consent from people before providing care and support.

There was a quality assurance process in place to assess and monitor the service, although this had not always been effective in identifying improvements that were needed.

There were enough staff to attend all care visits and meet people's needs. Appropriate recruitment processes were in place to help ensure only suitable staff were employed.

People praised the quality of service they received. They were supported by staff who were suitably skilled and supported appropriately in their role.

Staff were caring, kind and compassionate. They knew people well and built positive relationships with them. They encouraged people to remain as independent as possible and involved them in decisions about their care.

Staff respected people's privacy and dignity at all times. They also took care to be as discreet and unobtrusive as possible when working in people's homes.

Where staff were responsible for preparing meals, they encouraged people to maintain a healthy, balanced diet. They also supported people to access healthcare services when needed.

Staff were led by people's wishes and empowered people to make choices. They provided personalised care and responded promptly when people's needs changed.

The provider sought and acted on feedback from people and there was an appropriate quality assurance process in place.

People, their relatives and staff felt the service was organised and run well. Staff were motivated and happy in their work and understood the expectations of the service.

The culture of the service was open and transparent. The registered manager notified CQC of all significant events. They responded positively and promptly to address issues raised during the inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Staff knew how to protect people from identified risks. However, there was a lack of information in one person's care plan to help ensure staff took consistent action to keep the person safe.

People's medicines were managed appropriately, although there was a lack of information to support staff to administer one person's 'as required' medicines safely.

There were enough staff deployed to attend all calls and meet people's needs. Smartphones were used to help ensure visits were not missed. Appropriate recruitment procedures were in place and pre-employment checks were completed before staff started working at the service.

Staff understood their safeguarding responsibilities and knew how to identify, prevent and report abuse. There were plans in place to deal with foreseeable emergencies.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not follow legislation designed to protect people's rights. However, they did seek verbal consent from people before providing care and support.

Staff were suitably trained and competent. They were supported effectively in their role by supervisors and managers.

Staff encouraged people to maintain a healthy, balanced diet. They monitored people's health and supported them to access healthcare services when needed.

Is the service caring?

Good

The service was caring.

Staff worked in a caring and compassionate way. They were kind and treated people with consideration.

People appreciated having regular care staff who they had got to know well and with whom they had built positive relationships.

Staff protected people's privacy and dignity at all times. They involved people in planning the care and support they received.

Is the service responsive?

Good

The service was responsive.

People received personalised care that met their individual needs.

Care plans were reviewed regularly. Staff acted promptly when people's needs changed and empowered them to make choices.

The provider sought and acted on feedback from people to help improve the service. There was an appropriate complaints policy in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

There was a quality assurance process in place to assess and monitor the service, but this had not always been effective in identifying areas of improvement.

People and staff praised the management of the service. Staff were motivated and understood the expectations of the service.

There was an open and transparent culture. CQC were notified of all significant events.

Carewatch (Isle of Wight)

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.

This is the first inspection of the service as it was only registered with the current provider in March 2016. The inspection was announced. We gave the provider 48 hours' notice of our inspection as it was a domiciliary care service and we needed to be sure key staff members would be available.
The inspection was conducted by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience was used to conduct telephone interviews with people and their relatives. The inspector visited the service's office on 20 and 27 April 2017.

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 service, what the service does well and the improvements they plan to make. We reviewed the information in the PIR, along with other information that we held about the service including reports of inspections conducted under the previous provider as there was continuity in the persons running and managing the service. We also reviewed notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 11 people who used the service, or their relatives, by telephone. We visited and spoke with three people and their family members at home. We also met and spoke with one person at the service's office. We spoke with the registered manager, two care coordinators, a quality officer and 13 care assistants. We looked at care records for eight people. We also reviewed records about how the service was managed, including staff training and recruitment records. Following the inspection, we received written feedback from the local authority's commissioning team and children's services team.

Requires Improvement

Is the service safe?

Our findings

Staff did not always have access to adequate guidance to help ensure individual risks to people were managed appropriately. Supervisory staff completed assessments to identify any risks to people using the service or the staff supporting them. These included environmental risks in people's homes and risks relating to the health and support needs of the person. Staff were aware of the action they needed to take to minimise the risk of harm to people; however, people's care plans did not always support staff to achieve this as the care plan for one person did not contain sufficient information to help ensure staff took appropriate action consistently.

One person was at risk of developing a serious condition linked to spinal injuries that could require urgent medical assistance. The staff member supporting the person was clear about the possible causes, signs and symptoms of the condition and there was some generic information about this in the person's care plan. However, there was limited guidance to staff about the action they should take if the person became unwell. The guidance that was available was out of date as it advised staff to administer a medicine that the person no longer had access to. In addition, the guidance directed staff to check the person's blood pressure daily, but the staff member told us they no longer did this. The person received all their food via a percutaneous endoscopic gastrostomy (PEG) which is a tube that allows food and medicines to be given directly into the stomach. They were not able to take anything orally as they were at high risk of choking. A staff member described how they administered mouth care to the person, to keep their mouth clean and moist, but there was no risk assessment in place to provide guidance to staff about how to do this safely. A family member of the person told us they were concerned that not all staff would know how to support their relative in an emergency and felt the information available was "all too vague".

We discussed risk management with the registered manager, who acknowledged that more information was needed in this person's care plan. They took immediate action to address this.

Other people had access to pendant alarms linked to a monitoring service; if they fell while on their own, the alarm would activate and help would be sent by the monitoring service. Records showed that staff made sure that people were wearing the alarms, before leaving them after each call.

Where people required assistance to take their medicines, these were managed and administered appropriately. The provider had a clear medicine policy which stated the tasks staff could and could not undertake in relation to administrating medicines. For some people, the help required was limited to verbally reminding them to take their tablets; for other people staff needed to administer medicines to them, for which they had received appropriate training. Following the training, supervisory staff assessed the competence of the staff member to administer medicines and offered further support if needed. One person received all their medicines via their PEG. The staff member who did this had received training and was clear about how this should be done; however, there was a lack of information in the person's care plan to guide staff and ensure that care planning reflected the training that had been provided to promote consistency. We discussed this with the registered manager who took immediate action to ensure additional information was added to the person's care plan.

Checks of a random selection of medicine records showed people had received their medicines on time and as prescribed. Where people needed support to apply topical creams, there were body maps in place showing the area of the body to which each cream should be applied.

There were sufficient numbers of staff available to attend all calls. Staffing levels were determined by the number of people using the service and their needs. The registered manager told us new care packages were only accepted if sufficient staff were available to support the person. Office staff produced a schedule each week, showing the times people required their visits and the staff that were allocated to them. These were then sent to the person so they knew who would be supporting them at each visit. Some people needed the support of two staff members to support them to move or reposition and family members confirmed that two staff always attended such calls.

The provider had issued staff with smartphones that allowed them to record when they arrived to support a person and when they left. If the staff member failed to arrive or leave as expected, an alert was sent automatically to supervisors, so they could make enquiries. This system helped ensure calls were not missed inadvertently and supported the safety of staff who worked alone.

Travelling time between calls was built into the staff rota which usually allowed staff to arrive on time. One person told us, "[Staff] are always on time. I get half an hour for each visit and they stay the full time." Another person said, "The odd times they are late due to traffic or something like that. It is not a problem for me." A survey by the provider in 2016 showed that 96% of people were satisfied with the timeliness of calls. However, two of the 11 people we spoke with were critical of the variation in call times that they experienced. One of them told us, "[The care assistants] can come anytime between 7:00am and 9:10am and we never know when it will be. It makes it difficult to plan properly." We discussed call times with the registered manager who told us they had experienced problems in one geographic area due to staff sickness, but had recently addressed the issue. They had also identified people who became particularly anxious if the time of their visits was changed and had prioritised these calls to enhance the consistency of visit times.

Appropriate recruitment procedures were in place to help ensure that only suitable staff were employed. Staff files included full employment histories and records of interviews held with applicants, together with Disclosure and Barring Service (DBS) checks. DBS checks help employers make safer recruitment decisions. References had also been sought from relevant people, including previous employers, to check applicants were of good character. Staff confirmed these procedures were followed before they started work at the service.

People benefited from a service where staff understood their safeguarding responsibilities. One person said, "Nothing worries me with them [staff]." Another person told us, "Someone [staff] comes around to check on me and make sure I am safe." A safeguarding policy was in place and staff were required to complete safeguarding training as part of their induction. The service supported children as well as adults and we saw that staff who worked with children had also completed child protection training. Staff were knowledgeable about the signs of potential abuse and the relevant reporting procedures. One staff member described how they had liaised with the local safeguarding team after identifying that a person was at risk of abuse from a family member. They continued to monitor the person's welfare and looked out for relevant warning signs. Another staff member told us, "I'm always on the lookout for signs [of abuse], for example if they are unusually quiet or have unexplained bruising, especially in unusual places. If I had any concerns I'd inform one of the managers or CQC."

The registered manager shared details of a safeguarding referral they had made following an allegation of

financial abuse. The record showed they had conducted a thorough investigation, in liaison with the local safeguarding team and the police. They had then taken appropriate action, in line with the provider's employment procedures, to protect people from further harm.

The service had a business continuity plan in case of emergencies. This covered eventualities including extreme weather. They had assessed the vulnerability of people and identified those most at risk if service provision had to be reduced. This would help ensure people received the necessary support in an emergency. In addition, all staff were trained to administer basic life support to people.

Requires Improvement

Is the service effective?

Our findings

People praised the quality of service delivered by staff. Comments from people included: "We get regular staff. They know what they are doing, they are all very good"; "They [staff] do a really good job"; "[Staff are] very knowledgeable, they always know what is going on"; and "I think they are really well trained".

Although people and their relatives were satisfied with the service, we found that staff responsible for planning people's care did not ensure that people's rights were protected in accordance with the Mental Capacity Act 2005 (MCA). The MCA requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any decisions made on their behalf must be in their best interests and as least restrictive as possible. Although some of the people receiving support from the service had a cognitive impairment, no MCA assessments had been conducted to consider whether they had capacity to make decisions about their care and support.

Where people had capacity to consent to the care and support they received, they had signed their care plans to indicate their agreement with it. Where they were unable to do this, family members who said they had a Lasting Power of Attorney (LPA) in place had been asked to sign consent forms on behalf of the person. An LPA is a legal authority that allows an appointed person to make decisions on behalf of another when the person lacks capacity. However, staff had not checked that the LPAs covered decisions relating to the person's care and welfare. When we checked with one family member, we found their LPA was only valid for financial decisions. They did not have the power to make decisions about the care and support being delivered to their relative by Carewatch staff. We discussed this with the registered manager, who agreed it was an area for improvement. By the end of the inspection, they had completed an MCA assessment for the person, together with a best interests decision about the care and support they were receiving. The registered manager also put new procedures in place for checking LPAs in relation to other people in their care.

Staff were clear about the need to seek consent from people before providing care and supported people to do so. One person told us, "They [staff] talk to me about everything that is going to happen and ask 'Do you want to do this or that?'."

People were supported by staff who were suitably trained, skilled and competent. Staff underwent a comprehensive induction programme to help ensure they had the required knowledge and skills to provide people with appropriate care. This included a five day classroom-based training programme, followed by 'shadowing' where they worked alongside experienced care staff until they felt confident and competent to work unsupervised. Arrangements were also in place for staff who were new to care to complete training that met the standards of the Care Certificate. This is awarded to staff who complete a learning programme designed to enable them to provide safe and compassionate care to people.

Experienced staff were required to maintain and refresh their knowledge on a regular basis. This included essential training, such as moving and handling, infection control, safeguarding adults and first aid. In addition to the scheduled training, staff could request any extra training they felt would benefit people. For

example, one staff member told us they had asked for, and been given, extra tuition in the use of a hoist and other staff had completed training in end of life care.

Staff were also supported to gain vocational qualifications in health and social care. A care coordinator told us they were being supported to complete a level five qualification and the registered manager had been selected for development training at the provider's academy. They told us, "The academy is a good thing. It boosted my confidence and I got a lot of learning out of it, particularly around accountability."

Staff were appropriately supported in their work. All staff received a range of supervisions with the registered manager or a supervisor. Supervisions provide an opportunity for managers to meet with staff, feedback on their performance, identify any concerns, offer support, and discuss training needs. In addition, staff received 'field observation checks' where one of the quality officers observed their practice and provided feedback. Staff told us these checks were useful and were conducted in a supportive way. One staff member said, "Supervisions are helpful. They let us know if we're doing something wrong or if there is a better way to do something". Another said, "They help me a lot and give me a chance to learn." Staff also had access to an 'on call' supervisor to provide advice out of hours. A staff member told us, "There's always someone to help you over the phone. I was unsure once whether to give a medicine, so I checked with them and they told me what to do." Another staff member added, "It's not a job you can do without support. I know I can call [a particular supervisor] anytime, day or night, and she is there for me."

Staff were able to demonstrate an understanding of the training they had received and how to apply it. For example, they explained how they communicated with people living with dementia by remaining patient, asking simple questions and providing continuous reassurance. One staff member described how they encouraged and supported a person who was living with dementia to eat. They said, "At lunchtime, [one person] thinks they have already eaten, when I know they haven't. I prepare something anyway and put it in front of them. When they smell it, it triggers something in the brain and they respond and eat it."

Most people's meals were prepared by family members. Where care staff were responsible for preparing meals, they encouraged people to maintain a healthy, balanced diet based on their individual needs and preferences. One person said of the staff, "They are great cooks, the meals they prepare are superb." Staff also supported people to drink well. A staff member told us, "When I offer [one person] a drink, she says she has already had one, but I know she hasn't as she can't manage it and her lips are dry; so I always make her one anyway and leave another one with her when I leave." Where people had special dietary needs, such as a soft diet, the need for this was recorded in their care plan and people confirmed they received their meals in an appropriate form.

Staff knew people well and monitored their health on a daily basis. If they noted a change they would discuss this with the person and their family member, if appropriate. With the person's consent, they then sought appropriate professional advice and support, for example from doctors and community nurses. One person told us, "Once I fell over and they [staff] called the ambulance for me." Essential contact numbers for relevant professionals were available to staff to enable referrals to be made promptly. In addition, where requested, staff accompanied people to healthcare appointments to provide support.

Good

Is the service caring?

Our findings

People's needs were met by staff who worked in a caring and compassionate way. People and relatives told us staff were kind and considerate. Comments from people and their relatives about the staff included: "They are very good at making me feel at ease"; "They are caring people and they help me whenever they can"; "It's just the way they talk to you; they seem to understand and want to help me"; and "They always seem to be interested in me". A family member echoed these comments and told us, "[My relative] became unwell and the carer had to phone 111 for an ambulance. [The carer] stayed until the ambulance arrived. It was nice to know we had that back up."

Although one person said they experienced continual changes of staff, all other people said they had a core team of regular staff and had built positive relationships with them. Feedback from a representative of Children's Services at the local authority said they had experienced "minor issues" with care staff being changed, but added: "Families have reported that some good relationships have been built with [care] workers [and] the children enjoy the time they have with them."

People told us staff consistency had improved in recent months. For example, one person said, "They [staff] used to change a lot, but it has got better recently. You never knew who was going to turn up at your door. They all knew what they were doing; they just didn't know me. I asked for a team of four and they are working superbly now." A staff member echoed this comment and told us, "I used to be sent all over the Island, but now I have the same people all the time. [People] like that they have a small team of [staff]."

People said they appreciated having regular care staff who they knew well. A family member told us, "They [staff] are lovely people and have become good friends they've been coming so long." Other comments from people included: "I have the same three carers that come round"; and "We want to get to know the staff. I had a word with the office at the beginning about sending consistent staff and they did what I asked them".

People were encouraged to be as independent as possible within their abilities and staff expressed a commitment to promoting independence. For example, a staff member told us, "'Supporting independence' is written on our uniforms. If I'm there to support someone, we will do [the task] together. It doesn't matter if it takes twice as long; I'm just there to do the bits they can't do. I wouldn't want to take away their independence." Another staff member described how they supported a frail person to make a cup of tea. They said, "[The person] wants to make you a cup of tea but can't manage the kettle. So I say 'Shall I boil the kettle and make a pot; then you can be mother?' That way they can still be involved." Care plans included some advice as to how staff could achieve this, although this was limited to comments such as "Support with daily skills to assist [the person's] independence". The registered manager acknowledged that more information was needed to help staff promote people's independence in a consistent way and undertook to address this immediately.

People said their privacy and dignity were respected at all times. One person said of the staff, "It's just the little things they do, like closing the door when I am getting changed." Another person said, "One time, my [relative] was around and the [staff member] wanted to help me get changed, so they took me into the

bedroom and I got changed there. They will also wait outside the toilet and wait until I am finished just in case I need some help."

Staff were sensitive to the fact that they were working in people's homes and took care to be as discreet and unobtrusive as possible. They described the practical steps they took to protect people's privacy and dignity. For example, a staff member told us, "You don't just turn up and walk in. You announce that you are there and wait to be invited in. You make sure to cover the parts of the body you're not washing; you use a dressing gown to keep them covered on the way to the bathroom; you close doors; and you maintain confidentiality." Another staff member described how they supported a person who was often unresponsive. They said, "We still talk to [the person] and explain what we are going to do. It would be rude not to."

Staff consulted people and involved them in decisions about the care and support they received. One person said, "I have had a chat with the manager and we discuss what I like and don't like"; and another told us, "We talk about [my care plan] all the time." The care planning process started with an assessment of the person's needs and developed over time as people's needs changed. People said they were also involved in reviews of their care and in discussing any changes they wished to make to the way their care and support was delivered.

Good

Is the service responsive?

Our findings

People consistently told us they received highly personalised care from staff who understood their care and support needs well. Everyone who was receiving care from the service, or their relatives, told us they were completely satisfied with the quality of care they received. One person said, "Everything in my care plan is done and [the staff member] will do everything the way I like it." Another person echoed this comment and said of the staff, "They're great, they really make an effort." A family member told us, "They [staff] do an amazing job, I think they're wonderful."

Staff were clear that they were led by people's individual wishes and accommodated them wherever possible. When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how each person preferred to receive care and support.

Assessments of people's care needs were completed by one of the supervisors, who then developed a suitable plan of care. Care plans covered a wide variety of topics, including: the person's normal daily routine, mobility, medicines, continence and background. They included a list of tasks staff were required to complete at each visit. However, the 'Individual needs and support plan', which provided advice and guidance to staff on how to support people, did not always contain enough information to support staff to deliver care in a consistent way. For example, information about people's personal care needs was limited to sentences such as, "Support with shower" and "Full assistance required with oral care". When we spoke with family members, they told us staff knew how to support their relatives, were "very experienced and used their common sense" and always provided appropriate support. Records of the care and support delivered by staff were clear and concise. They confirmed that people had received appropriate care in accordance with their needs and preferences. When we spoke with the registered manager, they acknowledged that people's care plans would benefit from further guidance and took immediate steps to address this during the course of the inspection.

Care plans were reviewed regularly by the service's quality officers and whenever people's needs changed. For example, staff had identified that one person required more support, so had discussed their concerns with the person's care manager. This had led to an enhanced package of care, including support for the person to access day care services at a local care home.

Staff responded promptly when people's needs changed. They recognised that some people's mobility or cognitive ability varied from day to day and were able to assess and accommodate the level of support the person needed from visit to visit. A person said, "[Staff] seem to pay attention to what is going on." A family member told us, "Because we have the same [staff], they pick up on things; like they spotted a [urine infection] recently." Another family member said of the staff, "They spot changes and let me know. They're very on the ball."

Staff were able to access the electronic care records system via the smartphones issued by the provider. This meant they could read the majority of people's care plans on-line and check the care records from the last call before they visited the person. This gave them access to key information about people's care and meant

they could spend more time with the person during visits, rather than reviewing their records.

People were empowered to make choices about every aspect of their lives, including when they received their care visits. One person said, "I can say what I like and they [staff] will try and help me." A staff member told us, "[One person] can choose what to wear and what she wants to eat. Sometimes she chooses not to get changed at night. We explain that she will be in her clothes all night; if she says 'That's fine', we say 'Okay'. Come morning, she'll be fine and ready for a wash and a change." Another staff member said, "We always ask the client what help they need as something may have changed, even if we know them well."

The provider sought and acted on feedback from people using a range of methods. Questionnaire surveys were sent to people and their relatives each year. Responses were then collated and analysed by staff at the provider's head office to identify themes for improvement that could be made locally. In addition, the registered manager reviewed the comments to enable them to address individual issues people had raised. A theme identified in the most recent survey was people's dissatisfaction with changes to their scheduled visits. The registered manager told us they had responded to this by prioritising people who became particularly anxious when their call times or staff team was changed. When we spoke with people, they reported fewer changes now than previously and felt they had been listened to. 'Telephone monitoring forms' were also used by office staff to record discussions with people and their relatives, together their views about the service they received. Responses we viewed were overwhelmingly positive and included comments such as "[The person] thinks carers are wonderful and has nothing but good things to say about them."

People knew how to complain and there was a clear complaints procedure in place. One person said, "If I had to complain, I'd call the office; but I've never had to." On rare occasions when people did not get on with one of their allocated care workers, we saw supervisory staff had made arrangements for the care worker to be changed. Later feedback showed people were happy with the way such incidents had been resolved. One person told us, "If I don't like [a member of staff], I will phone the office and they will make sure they never come back. It has happened once or twice and always been sorted."

Requires Improvement

Is the service well-led?

Our findings

There was a quality assurance process in place based on a range of audits conducted by the registered manager and the service's quality officers. In addition, the provider's regional manager visited each month to conduct reviews of the service. However, the process used to review people's care plans was not always effective. It had not identified that staff were not following the Mental Capacity Act or checking people's lasting powers of attorney; it had not identified the lack of information in people's care plans to support staff to provide care in a safe and personalised way that promoted people's independence; it had not identified a lack of guidance about the administration of one person's medicines.

We discussed these issues with the registered manager and one of the quality officers. They acknowledged these were areas for improvement and took immediate action to address the issues and introduce additional checks to help ensure people's care plans were reviewed effectively in future.

Other audits had been more effective in improving the quality of the service. For example, where gaps in medication administration records had been identified by the medication audit, we saw investigations had been conducted to ascertain the reason and action had been taken to reduce the error rate. Subsequent audits confirmed that the error rate had been reduced significantly.

People had confidence in the service. They told us it was organised and run well. Comments included: "This service is really good"; "Everyone I have met [from the agency] has been wonderful and really helpful"; and "I think they are a really good company". Written feedback from a representative of the local authority's commissioning team stated: "In terms of organising packages of care they are very good, clear on what they can and can't do (call times etc). [We] can always get them by telephone and email if needed and in general my team have a good relationship with Carewatch IW."

There was a clear management structure in place. This consisted of the provider's management team, the registered manager, care coordinators and quality officers. Teams of care assistants covered specific geographical areas, although there was flexibility for some staff within the teams to cover other areas when needed.

People benefitted from staff who were motivated and happy in their work. Comments from staff included: "I'm very happy with the company; it was the best move I ever made"; "I feel valued and listened to"; "I like the company. They are good and I like the team"; and "The management is good and the office have been very accommodating".

Staff told us managers were always supportive, particularly when they experienced personal problems, such as illness. Comments from staff about this included: "I feel supported having [had an accident]. The supervisor came round to see me and I've been put back on light duties. They've swapped two calls around to make it easier and are allowing me extra time to get from call to call"; and "The office were absolutely phenomenal [when I experienced sickness in the family]. I could not have asked for more support".

Most staff told us their duties were organised well and they knew what was expected of them. However, two of the 13 care assistants we spoke with were critical of the way calls were allocated. One said, "Overall the schedule is okay, but there are times you get calls that haven't been notified [to you]. Communication could be better" The other staff member echoed this and added, "Sometimes calls get squeezed in between other calls. I have had to contact the out of hours [supervisor] saying I can't fit all the calls in. It makes you feel under pressure." The registered manager said they were aware that there had been a shortage of staff in one area, due to sickness, but felt things were improving. This improving picture was confirmed by people we spoke with, who said the timeliness and consistency of visits had got better recently.

The registered manager was clear about the standards they expected staff to work to. They said, "I look at it as if [people receiving the service] were my parents and how I'd want them looked after." Standards were monitored through the quality officers who conducted 'field care observations' to check staff were working to the required standards. The checks included punctuality, safeguarding, moving and positioning practices, medicine administration, dignity and respect. Where the checks indicated staff needed additional support, this was provided. A staff member said of the checks, "Sometimes they are announced and sometimes not. They keep you on your toes." One of the quality officers told us, "The company want quality; they want care to be client based and to support people to maintain independence in their own homes." Staff meetings were used by managers as an opportunity to reiterate the values of the service. For example, minutes of the meetings showed staff had been reminded of the need to maintain confidentiality and to accurately record the care and support they had delivered to people.

There was an open and transparent culture within the service. Staff described the management as "approachable" and said they were made welcome when they visited the office. The registered manager notified CQC of all significant events. There was also a duty of candour policy in place to help ensure staff acted in an open and transparent way when mistakes were made. We saw this was followed after an incident where a staff member had not spent the required amount of time with a person. The registered manager was receptive to feedback throughout the inspection and acted promptly to resolve any concerns raised. They also described how they had fed back to senior managers, so learning from this inspection could be used to drive improvements at the provider's other branches.