Care Quality Commission

Carewatch Care Services Limited

Carewatch (Tyne & Wear)

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?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 9 and 12 November 2015 and was announced.

We last inspected this service in July 2014. At that inspection we found the service was meeting all the legal requirements in force at the time.

Carewatch (Tyne & Wear) is a domiciliary care agency providing personal care for older people, some of whom have a dementia-related condition. It does not provide nursing care. There were 669 people using the service at the time of this inspection.

The service had a registered manager who had been in post for two years. 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.

People told us they felt safe and protected with their care workers. A policy was in place for safeguarding people

Summary of findings

who received the service from abuse. All staff had been trained in safeguarding and staff we spoke with were clear about their responsibilities for recognising and reporting any actual or potential abuse.

Risks to people and staff were appropriately assessed and managed.

There were not enough managerial and administrative staff employed to safely support the running of the service.

Records of the administration of people's medicines were poor and did not clearly demonstrate people received their medicines as prescribed.

Staff were given regular training and people told us their workers had the knowledge and skills necessary to meet their needs. However, staff were not provided with the supervision, appraisal and support they needed to carry out their roles effectively.

People's rights under the Mental Capacity Act 2005 were not always upheld as people's capacity to consent to their care was not always documented.

People's health needs were assessed and met, and they were encouraged and supported to have a nutritious diet.

People told us they were happy with the quality of their care and told us their workers were kind and caring. Relatives also praised the care staff's friendliness and the respect they showed to people. People's dignity and privacy were upheld, and they were helped to keep as independent as possible.

People told us they rarely needed to complain about their service. However, where complaints were received they were not fully recorded or responded to appropriately.

People said they felt involved in assessing their needs and in planning their care. Records showed a person-centred approach was taken to people's care and steps were taken to avoid social isolation.

The service had expanded in an unplanned way in the previous year, and the necessary staff and other resources required to maintain a quality service had not yet been fully put in place. Systems for monitoring the quality of the service were in place and had identified most areas requiring improvement. The registered manager and the provider's representatives were aware of the deficits and were open and honest about the need to consolidate the service and improve resources and lines of accountability.

Summary of findings

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 fully safe. Records of people's medicines did not confirm they always received their prescribed medicines.

There were insufficient managerial and administrative staff employed to support care workers in the carrying out of their role.

Staff were trained and knowledgeable about safeguarding people from harm and abuse.

Risks to people were assessed and managed appropriately.

Is the service effective?

Requires improvement

The service was not fully effective. Staff were not supported by a system of effective supervision and appraisal.

Staff were given regular and appropriate training, and had the skills and knowledge to meet people's needs.

The service was not always upholding people's rights under the Mental Capacity Act 2005 as people's capacity to consent to their care was not always documented.

People's health issues were assessed and monitored and they were supported to have a nutritious diet.

Is the service caring?

Good

The service was caring. People and their relatives told us their workers were kind, considerate and caring.

People's dignity and privacy were upheld. They told us they were encouraged to be as independent as possible.

People were given good information about their rights and about the services available to them.

Is the service responsive?

Requires improvement

The service was not fully responsive. Although few complaints were received, these were not fully recorded or responded to appropriately.

People were involved in assessing their needs and in planning their care, which was person-centred.

People were supported in maintaining activities and personal relationships, to avoid social isolation.

Summary of findings

Is the service well-led?

The service was not always well led. The service had expanded in an unplanned way and without the necessary staff resources to ensure it remained effective.

Systems for monitoring the quality of the service were in place, but these had not proved effective in maintaining standards.

The management team was open and honest about the need to consolidate the service and improve resources and lines of accountability.

Requires improvement

Carewatch (Tyne & Wear)

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 was 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 inspection took place on 9 and 12 November 2015. The inspection was announced. We gave the provider 48 hours' notice as the service is a domiciliary care agency covering a large area and we needed to be sure the registered manager was available to assist the inspection.

The inspection team was made up of one adult social care inspector, a specialist advisor, 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.

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 improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities' commissioning and safeguarding teams and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we talked with 14 people and three relatives. We sent surveys to 50 people and their relatives asking their views and received responses from 15 people and two relatives. We spoke with 12 staff, including the registered manager, regional operations director, regional quality auditor, deputy manager, care co-ordinator, field care supervisor and three care workers. We reviewed a sample of eight people's care records; six staff personnel files; and other records relating to the management of the service, including staff recruitment, supervision and appraisal records; people's medicines records; complaints; and quality systems.

Requires improvement

Is the service safe?

Our findings

People told us they were protected by their care workers. One person told us, "I feel very safe with all the carers." Another person commented, "I have confidence in my carers. I feel very safe when they are in my house." All the people who completed surveys told us they felt they were safe from any harm from their care workers.

The service had a policy in place for safeguarding people who received the service from abuse. This was in line with local and national guidance. It included a checklist to ensure all appropriate steps were taken in response to concerns raised. All staff had been trained in safeguarding people from abuse and received regular training updates. Staff we spoke with were clear about their responsibilities for recognising and reporting any actual or potential abuse. Safeguarding records showed the service was prompt in reporting such issues to the required agencies, and that they carried out any investigations when requested.

A 'disclosure and whistle blowing' policy was in place. Staff were instructed to inform the provider of any issues of poor practice, and were given both a telephone helpline and an email address to do this. We noted there had been four episodes of staff whistle blowing in the past year. All were from staff working in the Darlington area, alleging a range of concerns. These allegations included a lack of training, supervision and support by the service in recent months. We saw the registered manager and regional manager had taken positive steps to address the issues raised. These included holding meetings with the relevant staff team and writing to each care worker setting out the actions being taken to improve staff support.

People's care and treatment was planned and delivered in a way that protected them from unlawful discrimination. They were given contracts informing them of their rights and giving them information about how to make a complaint.

The service carried out assessments of possible risks to people using the service, as part of the person's overall assessment of needs. Where risks were identified, a care plan was drawn up, with control measures and guidance to staff. Risk assessments were reviewed at least annually. Steps were also taken to protect the safety of staff. A 'lone working' policy and risk assessment was in place, and there was a 24 hour 'on-call' back up system for workers to use for advice. All staff were offered personal alarms, and personal protective equipment such as disposable gloves and aprons were provided. The service kept a log of all accidents and incidents affecting people using the service and staff.

A 'business continuity plan' was in place. This aimed to ensure that, in the event of emergencies such as severe weather or failure of essential services, critical functions such as the provision of complex personal care and people's medicines would still be delivered as safely as possible.

We looked at the staff available to meet people's needs. We were told that, in the previous six months, there had been a significant increase in the number of people using the service. This had come about when the service had taken on the management of two other Carewatch branches in the region. The service had also taken on the contracted hours of another local domiciliary agency in that time. This had resulted in a significant increase in the number of care workers employed by the service. However, there had not been a corresponding increase in the numbers of managerial and administrative staff. As a consequence of this, there had been a significant impact in many areas of the service. These included a reduction in the support given to workers, in terms of contact, supervision and appraisal; a decrease in the quality of general record keeping; and a lack of attention to quality audits and resulting action plans. Feedback from people using the service and their relatives indicated this had not had a major impact on people's safety. However, we noted isolated incidents of missed medicines calls and late or missed calls, due to the difficulties of managing a much increased service over a wide geographical area without extra management and administrative support.

This was a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The provider's representatives acknowledged the service had been significantly affected by this unsupported expansion in the workforce. They told us they were actively recruiting appropriate staff at all levels to mitigate the effects. We examined a sample of staff recruitment records and found the process used to be robust and appropriate.

We looked at the systems in place to ensure the safe handling and administration of people's medicines. A

Requires improvement

Is the service safe?

policy was in place and all staff who administered medicines had been trained, and received annual refresher training. The competency of staff members to safely support people with their medicines was regularly checked, including during staff induction, at the end of their probationary period, and as part of regular field observations by supervisors. We were told that staff deemed not to be competent, or who made repeated errors, were given further training and shadowing opportunities, but that disciplinary action was taken in cases of continuing lack of competence.

An appropriate general medicines risk assessment was in place. This stated people could only be supported by trained, competent staff who followed the provider's policy and administered medicines as per the prescribing GP's instructions. People's individual medicines risks assessments were not, however, robust, asking only if the person could self-medicate, needed prompts, or needed staff to administer. Corresponding medicines care plans were brief and did not clearly specify the role of the care worker with regard to the individual's needs. For example, where a person was usually able to take responsibility for taking their medicines but sometimes needed to be prompted, this was not made sufficiently clear.

There was a system in place for auditing the quality of staff recording on people's medicines administration records (MARs). The registered manager told us this was carried out on 20% of all MARs every month. We looked at a sample of the audited MARs. We saw regular gaps in the MARs, both in the recording of medicines administered and in other sections of the MAR such as the sections for recording people's allergies, their GP and pharmacist contact details, and the times of administration. We saw one example where inappropriate staff rostering meant one person was not administered one dose of pain relief four weeks running because there was an insufficient time gap since the previous dose. This issue had not been picked up as part of the audit of the person's MAR. These issues meant we could not be assured people were always receiving their medicines as prescribed.

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

Requires improvement

Is the service effective?

Our findings

We surveyed the views of 15 people who used the service and two relatives. 80% of the people and relatives we surveyed said they received reliable support from familiar and consistent care workers. They told us that, although their workers were not always on time, they usually stayed for the agreed length of time and completed all the tasks they should during their calls. One person said, "The carers do everything I need." A second person told us, "I am never rushed during my call." Other comments received included, "Very reliable service"; "The carers have not been late at all and they have been coming for two years"; and, "When the carers are going to be late I get a call to tell me, which is good."

Relatives were equally positive about the effectiveness of the service. One relative commented, "(Name) is very happy with the care they receive. They have regular carers and they always let them know if they are going to be late."

The feedback from people receiving services in the Darlington area was less positive about the reliability their services. The closure of the Darlington office and the transfer of management responsibilities to the Newcastle office in April 2015 had, we were told, significantly affected the service in that area. One person told us, "They (the office) don't seem to have any idea of distance between areas so the carers are often late or they are worried about being late for their next job." A second person said, "Things have changed recently, I never really know who is coming. I wish I did, as I don't like change, really." A number of care workers contacted us with similar concerns about the organisation in the Darlington area since the closure of its office. They told us they found communication with the office difficult and the organisation of their working day ineffective, making it hard to provide consistent care.

People told us their workers had the skills and knowledge necessary to meet their needs. Comments received included, "The staff are well trained. They all know what they are doing"; "I am never rushed, and they are well trained"; and, "When new carers start, they come with another carer for a few days, until they know the ropes."

All new staff underwent a structured five day induction process. This included all areas of training required by law, including first aid, moving and handling, health and safety, safeguarding adults and medicines. Following this, they were required to undertake a minimum of 25 hours of job shadowing with trained members of staff before they could work independently.

We looked at the records kept of staff training, including the staff training matrix. Excluding staff on maternity leave and long term sick leave, we found that staff were kept up to date with all the training necessary to meet their needs and protect their health and safety. A computerised system flagged up when a staff member was nearly due for retraining, and we saw evidence of future staff training having been booked. The service had its' own qualified and experienced trainer and had a dedicated, well-equipped training suite at the office. We noted staff were actively encouraged to study for Diplomas in health and social care.

We noted new care workers were required to have a review of their performance at the end of their probationary period. However, the majority of staff were recorded as not having had such a review. Similarly, we found that workers had not been receiving regular supervision in the past year, with some staff not having had the opportunity to formally discuss their work or concerns for many months (in some cases, over a year). The supervision policy also included a commitment to carry out regular observations of care workers' performance in the field, but this had not taken place for some workers in the previous year. The arrangements for staff appraisal were inadequate, with 40% of staff overdue for their appraisal. This meant staff were not receiving the support they required to carry out their roles effectively.

This was a breach of Regulation 18 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

We looked at how the service met its responsibilities under the Mental Capacity Act 2005 (MCA). This act 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.

The service had a 'capacity and consent' policy. This aimed to ensure staff acted in line with legislation and current guidance with regard to the principles of consent and

Is the service effective?

mental capacity assessment. However, we found that the policy was not being followed in practice. Consent forms were on each person's care record with regard to issues such as personal care, administration of medicines, access to personal confidential information, and involvement in assessment, care planning and review processes. We found that people's capacity to give consent to these areas was not always clear. Some local authorities assessed the capacity to consent to care of the person they were referring. Where this was not the case, there was no section of the provider's needs assessment that addressed the issue of consent. We found no evidence the service had initiated any assessments of mental capacity or been involved in 'best interest' decision-making meetings. We noted an internal service audit in September 2015 had identified there was only sporadic documentation regarding capacity to consent issues. This meant the service was not always upholding people's rights under the Mental Capacity Act 2005.

This was a breach of Regulation 11 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

Nutritional needs were assessed and included in people's care plans, where appropriate. Areas assessed included food choices, allergies, weight, independence and any special diets required. For example, one person's care plan stated, "(Person) has been diagnosed with dysphagia and must have all fluids thickened using prescribed food thickener, two scoops per beverage."

An assessment of people's health needs was carried out on referral. This included the person's medical history, medicines and their current health conditions. Care workers were informed of health conditions that they needed to recognise. For example, one person's health care plan stated, "(Person) has angina. The symptoms to look out for include chest pains, breathlessness, nausea and dizziness. Call 111 and the office."

Good

Is the service caring?

Our findings

People told us they found their care workers to be very caring. One person told us, "I have had carers from Carewatch for about six months now. At first I didn't really like them coming in my house but after my illness I couldn't manage to look after myself. The carers who came to help me really made it easy for me, they treated me with respect and were very friendly. I really look forward to them coming now." Another person said, "The staff are very caring." A third person commented, "I have the best carers the company has and I have had no problems at all." Other comments included, "All the staff are very caring. They have become real friends. I don't know what we would do without them"; "The carers are first class"; "I have the best carers in Darlington"; "My carer is absolutely amazing"; and, "They are my guardian angels."

All the relatives we spoke with said they were very impressed with the quality of care their loved ones received. One relative said "My (relative) is very happy with the care received. They have only praise for the carers." Another relative told us, "(Name) is very comfortable with what they do for them. They are always treated with respect and when they are helping them shower or dress they maintain their dignity at all times."

The service had a policy on the 'rights of the customer', which recognised the diversity, choices, values and human rights of every person receiving the service and made a commitment to respect those rights and values at all times. The needs assessment contained questions on people's religion, beliefs, preferred first language, any communications and the need for a translator. Religious and cultural outcomes were included in care planning. For example, we saw, "Christened, but does not practice any religion" in one person's care plan. Nutritional care plans included religious and cultural considerations.

Each person receiving a service was given a 'customer guide'. This gave them information such as the services they could expect to receive; how to contact the company (including out of hours) and other agencies; their rights and responsibilities; staffing structure; and comments and complaints procedures. It also made clear services which would not be provided, such as cutting toe nails and giving injections. The customer guide underlined people's rights not to be discriminated against, to be treated as an individual and to be helped to be as independent as possible. It also reminded people they could request a change to their care package at any time. People were asked to sign their copy of the guide to show their understanding of the contents.

A quarterly newsletter was sent to people using the service. The current edition included advice on keeping warm and safe during the winter months; heating; information on free 'flu vaccines; and giving links to other agencies providing services such as community clubs.

Staff were alert to issues of personal well-being. We saw emotional and mental well-being were specifically assessed. Care plans encouraged the free expression of emotions and recorded any issues of depression, anxiety, changes to general mood and demeanour, and professional support needed or being received, such as counselling. People were informed about the availability of independent advocacy services which could be arranged for them, if they felt the need for such support.

The service had a confidentiality policy which promised people their personal information and circumstances would not be shared with anyone outside the service, unless to do so was to protect their safety or well-being. A data protection policy was also in place, which prohibited unauthorised access to people's personal information.

People's right to privacy and confidentiality with regard to their personal circumstances and information were clearly set out in the customer guide. People told us their privacy and dignity were supported by their care workers. One person told us, "The carers are all very kind and treat me very well and always with the utmost respect." Another person said, "The staff are very respectful all the time to me and my wife." Care plans also reflected these values. We saw examples of people deciding not to complete the 'personal history' section of their assessment, with the recorded comment, "I will share this information with you when I know my carer better."

The large majority of people and relatives who completed surveys told us their care workers helped them to be as independent as possible. We saw many examples of people's independence being supported and enhanced. These included supporting people to do their own shopping; make their own meals; and choosing their own clothing. We saw examples of care plans that confirmed this. For example, we saw, "(Person) requires minimal

Good

Is the service caring?

assistance with the majority of personal care. It is important to promote (person)'s independence and self-worth by ensuring they are actively involved in day-to-day tasks."

The service did not specifically provide end of life care, but where this became relevant, we saw examples of good practice. One relative had sent a 'thank you' card to the service, saying, "With your support, we were able to give (person's name) their wish that they remained in their own home to the end of their life. We could not have done it without you."

Requires improvement

Is the service responsive?

Our findings

People told us the service was responsive to their needs and wishes, and treated them in person-centred ways. One person told us, "If I have any appointments the care staff will come in early and they help me get ready." People told us they got a good service from the office staff. A typical comment was, "The office staff deserve a special thanks as any queries or concerns we had were cleared up without hesitation."

The registered manager told us they ensured that any social worker making a referral to the service provided an up to date assessment of the person's needs, with an associated care plan. This was confirmed in people's care records. The service carried out its' own 'activities of daily living' assessment to ensure it could meet all the person's needs and undertook comprehensive risk assessments. Needs identified in the various assessments were addressed in the form of detailed care plans. These care plans were personalised to the individual and incorporated the person's wishes and preferences with regard to their care. For example, "(Person) prefers showers to baths, and prefers them in the morning." However, staff told us, and care records confirmed, that the assessments and care plan process for people in the Darlington area had effectively lapsed at the time of the transfer of management responsibilities to the Newcastle office.

People's abilities were included in their care plans, as well as their need for support, to ensure they did not become unnecessarily dependent on their care workers. The deputy manager told us it was planned to include discussion of the content of people's care plans in every staff supervision session. This was so that staff did not rely on the abbreviated 'task' list that summarised people's care plans. People told us they were happy with the content of their care plans. One person told us, "If a new carer comes, my care plan has everything in it to tell them what to do."

The policy on reviewing people's care packages stated they should be offered a face to face review of their care every six months, and a full re-assessment of their needs at least annually. Areas covered in the review documentation included the person's degree of satisfaction with the quality of their care; suggestions for improving their service; and other comments. People were asked to sign their review forms. The deputy manager told us there was a computerised system for flagging up when people's face to face and telephone reviews were due. However, we found the service was not fully up to date with people's reviews. We were told this was a result of staff shortages in recent months, but that new field care supervisors were being employed and the service had a plan in place to cover the backlog of reviews by the end of the year. People told us they felt involved in how their care was given. One person told us, "I have a care plan that the carers write in every time they come. If anything changes, it is written in straight away and my care plan is reviewed about every six months by the staff in the office."

The assessment and care planning process included a section on social inclusion. This looked at how the person could be helped to maintain important relationships, showed respect for the person's life achievements, and encouraged the involvement in social activities. This meant people were helped to avoid being isolated. One example seen in a person's care plan was, "(Person) goes out on enabling trips with carers, and enjoys going to local markets, charity shops and having lunch out on Sundays."

People's care plans reflected the choices they were encouraged to make about their daily lives. For example, one care plan stated, "(Person) will let carers know their choice of breakfast food as they like variety." One person told us, "The carers do me a meal on a lunch time every day. They always give me what I want."

None of the people and relatives we spoke with or who completed surveys said they had any complaints about the service. One person told us, "I have no complaints at all but if I had I would feel happy bringing up the problem and I feel it would be sorted." A second person commented, "I have never needed to complain about anything but I would ring the office if I needed it sorting."

Examination of the complaints records showed not all complaints received had been fully recorded and investigated. Records were incomplete and did not show a clear audit trail. For example, some complaints records did not show the name of the care worker involved, and there were no clear outcomes of complaints, so we could not be sure they had been properly resolved.

This was a breach of Regulation 16 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The service made efforts to ease the possible stress caused by transition between different services. As an example,

Requires improvement

Is the service responsive?

when taking over the contracts of another local domiciliary care agency, a detailed project plan was put in place to minimise disruption to people's care. The service had worked with the other provider and the local council to support continuity of care by, for example, employing workers from the other agency and ensuring care records were received and followed.

Requires improvement

Is the service well-led?

Our findings

A registered manager was in post. They told us they received good personal support from their line manager, but felt hampered in carrying out their managerial role due to a lack of staff resources during a period of rapid expansion of the service.

People told us they felt their service was well run. One person told us, "I have nothing but praise for the company. I have never had any issues of any kind since using Carewatch." Another person said, "The staff in the office know what they are doing." A third person said, "I have never had to contact the office for anything." Another comment received was, "The people in the office came and updated my care plan a few weeks ago. It's well-organised."

A minority of people receiving care in the Darlington area told us the closure of the local office had had an effect on their service, in terms of care worker time-keeping, reliability and communication with the office in Newcastle. One person commented, "If I have any issues, I let the carers know and they sort it with the office, because if I try to do it myself it never gets sorted, especially since the Darlington office closed." However, there was a consensus that things had improved, particularly regarding communication, in recent weeks, and several people praised their care workers for working very hard to meet their needs during a difficult period.

We found the service had undergone significant changes in 2015. The number of people using the service had increased when the service took over the contracts of another local domiciliary care agency. We saw this was a planned change, but that it had been hampered by a smaller number of staff than expected transferring over with people using the service. The Carewatch (Tyne & Wear) branch had also taken over responsibility for the management of two other Carewatch branches. The first of these changes had been planned. The second, caused by the resignation of the management team, had not been planned; was undertaken at relatively short notice; and was not accompanied by extra resources. This had resulted in the service lacking the ability to properly manage its' new responsibilities.

A regional quality manager had recently been appointed. This person had carried out an audit of the service in September 2015 that had identified a wide range of areas for improvement. These included a large backlog of care, medicine and other records awaiting auditing; failure to continue with quality monitoring systems, such as calls to people using the service and annual surveys of the views of people and staff; and lack of staff supervision and support. It found particular difficulties had been encountered in trying to co-ordinate three different tracking systems used to organise care workers' work, and without local management knowledge of the new areas taken on (for example, the distances between calls). The regional quality manager's audit acknowledged the impact of "severe staffing shortages" on the quality of the service. Steps had been and were being taken to address the outstanding issues, but we were not offered a clear overall plan of the actions required/being taken to address these issues. We judged the systems in place to assess, monitor and improve the health, safety and welfare of the services provided to people using the service were not effective; and that the service had failed to seek and act on feedback from people using the service.

This was a breach of Regulation 17 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

The provider's representatives were open and transparent about the difficulties experienced by the service in the past year. The regional operations manager told us they accepted the quality of the service had been compromised due to rapid expansion. They said they accepted that the registered manager and deputy manager had been unable to fulfil the full range of their management duties, due to their need to be 'hands on' in ensuring direct care provision was maintained during serious staff shortages. The operations manager said new staff had been recruited in the last two months. These included a new care co-ordinator, administrator, pay roll operative, field care supervisor and recruitment officer. We were told three new field supervisors were still required to support the staff and these posts were currently advertised. The operations manager had proposed to the provider that a community quality manager be recruited to monitor and inspect the quality of records such as assessments, care plans and medicines records held in people's homes. The management of the Darlington service had been allocated to the service's deputy manager.

The regional manager circulated a weekly newsletter to all branches and staff. Information included feedback from

Requires improvement

Is the service well-led?

other branches nationally; changes in methodologies, new starters/leavers, business development, quality issues, marketing and other communications. The tone was highly positive and inclusive with staff being congratulated on their hard work and achievements.

The service was keen to develop links with local communities. Staff carried out fund raising for charities such as MacMillan Nurses. The service sponsored local football teams, visited local schools, colleges and careers fairs to talk about its' work and give information about careers in care. Volunteers were encouraged and opportunities for work experience were offered. Some training courses were open to relatives and people interested in care work.

The registered manager told us the service recognised the contributions of care workers by holding carer's lunches, and by having 'carer of the month/year' awards. The chief executive officer personally gave out long service recognition awards.

The registered manager had recently attended the company's 'Regulatory Inspection workshops', to prepare managers for changes under the new legislation that applied to regulated services. The registered manager told us this had been very useful and had heightened their awareness of their responsibilities.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing Sufficient numbers of suitably qualified, competent, skilled and experienced persons had not been deployed to meet people's needs. Persons employed by the provider in the provision of regulated activities were not receiving the support, professional development, supervision and appraisal required to enable them to carry out their duties. Regulation 18 (1)(2)(a)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way because the management of medicines was not safe. Regulation 12 (2)(g)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider had not acted in accordance with the Mental Capacity Act 2005 with regard to people who were unable to give consent because they lacked the capacity to do so. Regulation 11(3)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints The system for identifying, receiving, recording, handling, and responding to complaints was not effective. Regulation 16 (2)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance Systems to assess, monitor and improve the quality of the services provided (including the quality of the experience of people receiving those services) were not effective. Regulation 17 (2)(a)(e)