Careline Homecare Limited

Careline Homecare (Newcastle)

Inspection report

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Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Good**
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 4, 5 and 11 and 12 February 2015 and was announced.

Careline Homecare (Newcastle) provides personal care and support to people in their own homes in the Newcastle area. At the time of our inspection, the service provided care and support to 394 people.

At our last inspection in January 2014 we found that improvements were required for medicines management and records. We issued a compliance action for medicines management and told the provider they must take action to improve. Following the inspection in January 2014, the provider sent us an action plan telling us what action they were going to take to improve.

There was a new manager who had been in post since December 2014. She had previously been a registered manager for another homecare service which the

Summary of findings

provider owned. She completed her application to register with CQC on the first day of our inspection. 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 and associated Regulations about how the service is run.

People told us that they felt safe with the staff who visited them. There were safeguarding procedures in place. Staff were knowledgeable about what actions they would take if they suspected abuse had taken place.

We found that the provider was working to improve the way medicines were managed. However, further work was necessary to fully protect people from errors resulting from poor medicines records.

Staff told us that there was sufficient training available. This was confirmed by training records which we examined.

Some people, relatives and staff told us that more staff were required to support people especially in the Gosforth area. This was confirmed by our own observations. Following our inspection, the regional manager wrote to us and explained that they had recruited a further six staff in this area.

People's nutritional needs were met. Staff supported people with their meal preparation. Healthcare professionals such as the GP or district nursing service were contacted if there were any concerns with people's health care needs.

We found that staff were knowledgeable about people's needs and they demonstrated a caring approach whilst supporting people.

People and relatives told us that they were involved in their care. They told us that they generally saw the same care workers or the same small team of care workers. However, there had been issues with late calls and calls where only one care worker had arrived when two were needed.

Some staff told us and our own observations confirmed that there had been an issue with missed calls. The regional manager looked into this concern and found that there had been 13 missed calls in February 2015.

There was a complaints procedure in place and people told us that they could raise any issues or concerns with staff. Some people, relatives and staff told us that they felt the office staff needed to be more efficient in responding to telephone enquiries.

Although there were systems and processes in place to monitor the quality of the service, we found that these were not always effective in highlighting the issues which we identified. In addition, the electronic call monitoring system [ECM] was not fully operational and missed calls were not being identified in a timely manner.

We received mixed views from staff about working at Careline Homecare (Newcastle). Some staff told us that they did not feel valued or supported in their work. Other staff told us that they enjoyed their jobs and felt supported by their line manager. We considered improvements were required to ensure that there was a positive culture within the service and visible leadership.

We had not been notified of the deaths of people who used the service which the provider is legally obliged to inform us of. The regional manager informed us that this would be addressed straight away.

During our inspection of the service, we found four breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. These related to care and welfare of people who use services; medicines management; staffing and assessing and monitoring the quality of service provision. In relation to medicines management this is being followed up and we will report on any action when it is complete.

These breaches corresponded with four breaches of the new Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to person centred care; safe care and treatment in relation to medicines; staffing and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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

Not all aspects of the service were safe.

We found that the provider was working to improve the way medicines were managed. However, further work was necessary to fully protect people from errors resulting from poor medicines records.

Some people, relatives and staff told us that more staff were required, especially in the Gosforth area. This was confirmed by our own observations. Safe recruitment procedures were followed.

People told us that they felt safe with the staff who visited them in their homes. Staff were knowledgeable about the action they would take if abuse was suspected.

Is the service effective?

Good

The service was effective.

Staff told us and records confirmed that they received appropriate training to meet the needs of people who were receiving a service.

People received food and drink which met their nutritional needs and they could access appropriate health, social and medical support, as soon as it was needed.

Is the service caring?

Good

The service was caring.

We spent time observing staff interactions with people who used the service. We saw that staff were kind and treated people with respect. People told us that staff were caring.

We observed that staff promoted people's privacy and dignity. They knocked on people's front doors before they entered.

Staff were aware of people's needs, their likes and dislikes and could describe these to us.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Most people and relatives told us that they generally saw the same care workers. However, sometimes staff did not always turn up on time or only one care worker arrived when two were required.

Staff told us and our own observations confirmed that there had been an issue with missed calls. The regional manager immediately carried out an investigation and looked into this area of concern.

Summary of findings

There was a complaints procedure in place. We looked at complaints which had been received and saw that these had been dealt with in line with the complaints procedure.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

There was a new manager who had been in post since December 2014. She was not yet registered with CQC in line with legal requirements.

Although there were systems and processes in place to monitor the quality of the service, we found that these were not always effective in highlighting the issues and concerns which we had found.

We received mixed views from staff about working at Careline Homecare (Newcastle). Some staff told us that they did not feel valued or supported in their work. Other staff told us that they enjoyed their jobs and felt supported by their line manager. We considered improvements were required to ensure that there was a positive culture within the service and visible leadership.

Careline Homecare (Newcastle)

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 team consisted of an inspector; a pharmacist inspector; a CQC analyst; a specialist advisor in governance and an expert by experience who had experience of homecare. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

The inspection took place on 4, 5, 11 and 12 February and was announced. We visited the service's head office on 4 and 5 February and carried out visits to people's homes on 5, 11 and 12 February. We announced the inspection 48 hours prior to our visit to the provider's head office, to ensure that the office was accessible and we were able to meet the registered manger or a senior member of the service. By announcing the inspection, the manager was able to facilitate our requests to speak with staff and organise visits and telephone calls for us to see and speak with people and their relatives. We accompanied eight care workers on their visits which they referred to as "calls" to see 20 people who were receiving a service. We accompanied the care workers from 7.30am until 9.30pm over two days in order to ascertain how care was delivered at various times of the day.

Following our inspection, our expert by experience spoke with 19 people and two relatives by telephone to obtain their views.

We spoke with the northern regional director, the nominated individual who was the head of quality; the regional manager; the manager; the deputy manager; the human resources manager; two field supervisors; four care coordinators and 12 care workers.

We examined 20 care plans and related medicines records. We also checked records relating to the management of the service such as audits and surveys. We looked at 10 staff recruitment and training files.

Prior to carrying out the inspection, we reviewed all the information we held about the service. The provider completed a provider information return (PIR). A PIR 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.

Requires Improvement

Is the service safe?

Our findings

All people with whom we spoke told us that they felt safe with the care workers who visited them in their homes. There were safeguarding procedures in place and staff were knowledgeable about what action they would take if abuse was suspected.

Staff were aware of what actions to take if they could not get a reply when they knocked on a person's door. We followed one care worker who knocked on a person's door and the person did not answer. The care worker telephoned the office, who contacted the person's social worker. A member of the office staff telephoned the care worker back to inform her that the person was not in the house since she had chosen to go out into the local community.

There were risk assessments in place which informed staff what actions they should take to minimise risks such as moving and handling and risks associated with medicines management.

We checked staffing levels at the service. We spoke with 19 people by telephone following our visits to the service. Eight people told us that more staff were required. Comments included, "They don't seem to have a bank of staff to call on," "The girls are run ragged" and "The carers are good but they need more staff. When someone is off, they lack the staff to cover and the system goes awry."

We spoke with six staff who worked in the Gosforth area. They all told us that staffing was an issue in Gosforth and there were insufficient staff to cover all the homecare visits. One staff member told us, "The other week I was so far behind, I was doing lunch time calls at 4pm. Someone is going to have to help."

Staff told us and people and relatives confirmed that sometimes staff did not stay the full length of the call. We spoke with staff about this issue. They explained and our own observations confirmed that they never left a person's house without completing all the necessary duties such as assisting with meals or supporting the person with personal care; but would sometimes leave early to try and make up time. We observed that care was sometimes rushed in the Gosforth area. We consulted with the manager and regional manager about this issue. Following our inspection, the regional manager wrote to us and stated, "All staff are aware they are to stay at calls for full allocated times."

We followed three care workers carrying out homecare visits in the Gosforth area. Two of these care workers walked to people's homes. Staff informed us that travelling time was not included and therefore they were sometimes late. Staff and people with whom we spoke informed us that this issue was particularly noticeable in the Gosforth area. Our own observations confirmed this. We left one person's house at 8.30am and had to be at the next person's house at 8.30am; which was a 20 minute walk away. This delay also affected the rest of the calls that morning. One relative said, "The staff are sometimes rushed, they finish here at 7.30 and they have to be somewhere else at 7.30, so they are sometimes rushed."

This was a breach of regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the regional manager about this issue. Following our inspection, she wrote to us and stated, "We had identified recruitment as a key issue in this area [Gosforth] and now have a dedicated recruiter who is currently prioritising the recruitment of drivers [care workers who drive] in this area. In the last two months we have appointed six additional workers in Gosforth and are continuing with further recruitment."

Staff with whom we spoke in the other areas we visited, in Dinnington and Newbiggin Hall, did not raise any concerns about staffing levels. We found that care was delivered in an unhurried manner in these areas.

At our last inspection on 16 January 2014, we found that people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage them safely.

The provider wrote to us and told that they intended to improve the way medicines were managed. They told us that they planned to improve communications with supplying pharmacies to address issues arising from supplies of medicines. They also planned to improve the assessment of care workers' knowledge of medicines.

Requires Improvement

Is the service safe?

At this inspection, we found that the provider was working to improve the way medicines were managed. However, further work was necessary to fully protect people from errors resulting from poor medicines records.

We found that appropriate arrangements were not in place in relation to the recording of medicines. Medicines records did not clearly identify those medicines that people were assisted with. Where medicines were supplied in blister packs, records showed that people had been assisted with the contents of the pack. However, records did not identify the individual tablets or capsules that people were assisted with. Whilst each person had a list of medicines, called a 'Medication profile' that they were assisted with, we found this did not identify which medicines were in the blister packs. The medicines lists for some people were also inaccurate and we found errors such as the incorrect dosage recorded, or medicines that were missed from the list. For example, the dosage of one medicine on the list was different to the dosage on the pharmacy label, and this was different to the actual dosage administered by care workers. There was no information available to inform us which dosage was correct. This could result in people being offered incorrect treatment.

We looked at the care plans to identify the level of support that people needed in order to receive their medicines safely. One care plan indicated that the person was assisted with medicines twice a day whereas they required assistance four times a day. We also found that where people were assisted with high risk medicines or received their medicines by tube-feeding the care plans did not provide staff with clear guidance on their safe management.

This was a continuing breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 12 (1)(2)(g) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider told us that they were reviewing the medicines training of care workers. We were shown the revised training package and saw that care workers were to be trained to record individual medicines that people were assisted with. The provider told us that this training would be rolled out in March 2015. The provider undertook spot-checks of medicines records to check that they were completed properly. Action points were seen to improve the way records were managed.

We spoke with the manager and regional manager about our concerns regarding medicines who immediately carried out an investigation into the issues raised. Following our inspection, the regional manager wrote to us and stated, "There have been discrepancies with the meds profiles and the actual prescribed meds, however the carers follow instructions on the MAR [medicines administration record] charts, not the profiles. These were all correct therefore carers are giving the correct medication."

Staff told us and records confirmed that relevant checks were carried out before they started work. These included Disclosure and Barring Service checks. Two written references were obtained. These checks were carried out to help make sure prospective staff were suitable to work with vulnerable people. We saw that checks were also carried out to ensure that job applicants were legally allowed to work in the UK. Some people and relatives with whom we spoke thought that more consideration should be given to recruiting the "right type" of care workers. We spoke with the recruitment officer about these comments. She told us that it was difficult at times to recruit and sometimes they had to give staff "a chance" to prove they could do the job. She told us that staff completed induction training before starting work.

Good

Is the service effective?

Our findings

Staff said that there was training available. This included vocational training such as National Diplomas in Health and Social Care which were previously known as National Vocational Qualifications (NVQ's). Staff told us and records confirmed that they had access to training in safe working practices such as moving and handling. We observed staff moving and transferring people. The correct procedures were followed.

Records confirmed that staff completed training to meet the specific needs of people who used the service such as those who required specialist feeding techniques; dementia care and end of life. We noted that one member of staff, who was line manager for a team, had not completed training such as moving and handling and safeguarding training. The manager told us that this training had been planned.

The manager told us and staff confirmed that one to one meetings known as supervision sessions were carried out. These are used amongst other methods to check staff progress and provide guidance. An appraisal was also undertaken.

Staff were knowledgeable about people's dietary needs and their likes and dislikes and could describe these to us. We observed staff support people with their nutritional needs. Staff followed safe working practices with regards to food hygiene and presented people's meals nicely. They took pre-prepared 'ready meals' out of their original packaging and presented them on a plate. Staff always asked people what they would like. One care worker said, "What would you like today, would you like soup? There's some leek and potato soup here." For pudding the person said, "I love rice pudding, I'll have some of that – you're a gud un [good one]." Another care worker set a tray with a cup of tea and the person's "favourite fig rolls."

We observed two care workers administering nutritional fluids to one individual via a Percutaneous Endoscopic Gastrostomy (PEG) tube. This is a tube which is placed directly into the stomach and by which people receive nutrition, fluids and medicine. The care workers ensured the person was in the correct position and observed them throughout the procedure for any signs of discomfort. One of the care workers told us, "We work as a team, while [name of care worker] is sorting out the medicines, I will give the feed."

We checked people's care plans and observed that staff contacted health and social care professionals such as GP's and district nurses if there were any concerns with people's health or welfare.

The manager and regional manager were aware of the Mental Capacity Act (MCA) 2005 and had relevant policies and procedures in place. The training officer informed us that more training on the MCA was in the process of being organised. This helped ensure people were safeguarded from excessive or unnecessary restrictions being placed on them. We read the service user guide which was included in each person's care file. This stated, "We always assume that you have mental capacity unless we have good reason to believe otherwise…We do all we can to help you make your own decisions" and "Your wishes and best interests will remain paramount even if you have difficulties with your mental capacity. Importantly, we will not try to stop you making a decision that is unwise if you have the capacity to make that decision." We observed that staff always asked for people's consent before carrying out any care and support. One care worker asked whether a person wanted to have a shower, another asked whether she could help an individual get up and dressed.

Good

Is the service caring?

Our findings

People and relatives with whom we spoke informed us that staff were caring. One person said, “They’re canny [nice].” Another person said, “They’re all very good and they’re caring.” Other comments included, “They are very good, caring, helpful and they look after me well,” “They are like good friends, we have a laugh,” “They are absolutely fabulous, so tolerant and patient,” “You couldn’t get better than these two, I love them” and “They are all very friendly and look after me well.” One person told us how one of the care workers had brought him a packet of smoky bacon crisps since they were his favourite.”

We observed that staff were kind to people and treated them with respect. Staff knew people’s likes and dislikes and described these to us. One staff member explained how the person loved her hot water bottle. When we arrived, the person told the care worker, “Ooohhh bring my favourite little thing here.” The care worker brought her the hot water bottle. We observed another care worker assist a person with mouth care. The care worker knew the person loved her “cocktail” flavour lip balms and asked the person what cocktail she wanted that evening.

Staff spoke with people throughout their visit and whatever task they were doing. We saw two care workers assist a person to move from her wheelchair to her armchair. They explained what they were doing throughout the transfer. At the end of the move, one of the care workers said, “The eagle has landed” and everyone laughed. The care workers knew she liked to keep a supply of hankies in her “special place” and ensured that she had a plentiful supply before they left.

People informed us that they knew their care workers well and care workers knew them. One person said, “Now, she gets me [knows me] and I have got to know her.” We saw one care worker trying to fix a person’s clock since it was important for him to know what time of the day it was. She told us that he loved music and ballet and put on a video of a Russian ballet for him to watch. She explained that she was in the process of booking tickets for them to watch an opera at the local opera house.

People told us that staff supported them to get ready. One person said, “They always help me and make sure I look nice and have my favourite Estee Lauder perfume on.” We saw another care worker put a person’s hair into a bun by using a special hairstyling aid. The person said, “She’s a good hairdresser.” The care worker knew that the person liked to feel her hair to check there were no stray hairs. She said, “There you are, have a feel, is that alright?” “Oh that’s good” was the reply.

We saw that staff promoted people’s privacy and dignity. One person did not want the care worker to close the curtains in the lounge while she was getting dressed. The care worker explained that she stood in front of the person with her back to the window to prevent anyone looking in from the outside. One relative told us, “They always help her get washed in the bedroom; it’s more private in there. They’re good with privacy and dignity.”

Most people informed us that they had received a telephone call or visit from office staff to seek their feedback. They told us that they felt involved in their care.

The manager told us that no one was currently using an advocate. She told us and records confirmed that there was a procedure in place should the need for an advocate arise. We checked the service user guide which was available in each person’s house. This stated, “We do realise that some people may have difficulty communicating or may be confused, bewildered or worried by the processes surrounding the provision of care. If you feel this way you may benefit from the use of an advocate.” Contact details were included in the service user guide.

Requires Improvement

Is the service responsive?

Our findings

Most people and relatives told us that they generally saw the same care workers. One person said, "We see the same group, we know them all." Other comments included, "It's an excellent service. I have a little group of regular carers. I know them and they know me. You don't have to say much because they know where everything is. They work together very well" and "We get a rota every week which is great. Continuity of carers is important to us."

People and relatives said however, that sometimes staff did not always turn up on time. One relative told us, "They are really late sometimes." One person said, "Sometimes they are late, especially the walkers." Two people told us that this sometimes affected the care they received. One person said, "It's variable when they turn up and the time varies without notification which means I'm waiting around before I can have a shower." One relative explained that she paid to have a care worker support her husband one night a week so that she could go to bingo. She informed us that the care worker often turned up late which meant that she missed the start of the bingo session. She said that she had telephoned the office about this issue and office staff had "acknowledged" her concerns.

Some staff, people and relatives told us that there was sometimes a delay in the second member of staff arriving if two staff were required. One person told us, "The carers are spot on but I've had to complain to the office in the past because they've only sent one carer when I have a double-up service." One staff member told us, "It happens on a regular basis [a delay in the second staff member attending]" and "Sometimes relatives have to help; it shouldn't happen, but it does." Another member of staff told us that they sometimes assisted a person to get up by themselves in the morning even though the care plan stated that two staff were required. This was because the second member of staff was sometimes late. We examined this person's log book to check what time the second member of staff arrived. We noticed however, that only one time was entered for both staff which meant we could not ascertain what time the second member of staff arrived. We spoke with the regional manager and the manager about this issue. Following our inspection, the regional manager wrote to us and stated, "Carers have been asked to report this into the office every time it happens in order that action can be taken. All carers are told of the importance to sign in the report book on arrival and leaving calls. A memo has been sent out to remind carers of this."

Some staff informed us and staff rotas confirmed, that sometimes staff were "double booked" in the Gosforth area. One care worker told us that they were down to carry out a visit at one person's house and were also down on the rota to visit another person at nearly the exact time." The staff member told us, "The rotas are a joke, they sometimes overlap." We spoke to the manager and regional manager about this. Following our inspection the regional manager said, "All staff are aware …to hand back any visits they are unable to complete. The co-ordinators will follow the 'carer handing back calls' procedures."

The provider had introduced electronic call monitoring [ECM]. ECM is the process of recording the start time, the end time and duration of home visits for people who are receiving home care. Staff 'clock in' and 'clock out' by telephoning a free number when they arrive and leave each home visit. ECM not only helps local authorities ensure that services are being delivered appropriately; it also helps to flag up any missed or late calls. We found however, that ECM was not always used by staff. We checked the ECM data and noticed that missed calls were identified. The office staff explained that this data was not necessarily accurate since staff did not always remember to log in and out of calls. This omission meant that it was not always possible to check in a timely manner whether there had been any late or missed calls.

We spoke with some staff who told us that there had been a problem with missed calls. We visited two people who confirmed that they had not received a call as planned. One person told us that he had not received his medicines and another informed us that she had had to make her own meal since staff had not turned up. She told us, "There was no one last night. Fortunately, I could just about manage to make a meal. It was b***** annoying though. It's just the office they don't seem to care."

This evidence of late arrivals, shortfalls in the numbers of care workers and missed calls showed that the care required, to meet some people's individual needs and to ensure their safety and welfare, was not being delivered

Requires Improvement

Is the service responsive?

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 9 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We spoke with the manager and regional manager about this issue. The regional manager commenced an investigation into our concerns. Following our inspection, she wrote to us and stated, "There was a rise in missed calls in February totalling 13 in all…In all instances the welfare of the service user was immediately checked and our policy was followed both in respect of investigating the cause of the error and taking action to address the issue. In respect of any medication that was missed as a result of these missed visits, this includes seeking medical advice and taking any action as advised."

We looked at care plans. We saw that these were personalised and contained details of people's individual needs and their likes and dislikes. We observed people's care and noted that care plans identified the care and support provided with the exception of medicines management which is discussed in the safe domain. One person with whom we spoke told us that her care needs had increased and she required more care throughout the day. She explained that staff had updated her care plan to reflect her additional needs.

There was a complaints procedure in place. We looked at complaints which had been received and saw that these had been dealt with in line with the complaints procedure. One person whom we contacted by telephone told us that she had made a complaint about a care worker. She told us that this member of staff had not been back and she felt that office staff had listened to her concerns.

Requires Improvement

Is the service well-led?

Our findings

Careline Homecare originally opened in Newcastle in May 1998. In April 2011 Careline Homecare became part of City and County Healthcare Group.

At our last inspection in January 2014; the previous registered manager had stood down from her post as manager and the provider's representative informed us that they had identified someone new to manage the service. At this inspection, we asked the regional manager about the management situation. She explained that she had briefly been manager in March 2014 before being promoted to regional manager. She said a new manager was appointed after March 2014 who had not registered with CQC. A further manager from one of the provider's other homecare services had come to manage Careline Homecare (Newcastle) in December 2014. We spoke with the new manager who confirmed that she had completed her application to register with CQC on the first day of this inspection. This meant from January 2014 until February 2015 there had been no registered manager in place in line with legal requirements. This issue is being dealt with outside of the inspection process.

One person told us that she had noticed that there had been, "Several changes in management in a relatively short space of time." She also said, "It would be nice if we were told of changes in management." A relative with whom we spoke said, "I wouldn't know who is in charge."

Some people and staff felt that the support they received from the office based staff could be improved. One person told us, "The girls are lovely, but the office needs a shake-up. They don't phone you back and sometimes they don't answer the phone." Another said, "The carers are fantastic, but the office needs reorganised." This view was echoed by a further three people whom we contacted by telephone who told us that the office staff needed to be more efficient in responding to telephone enquiries and planning the care workers' visits.

We received mixed comments from staff about working at Careline Homecare (Newcastle). Their opinions depended upon the area in which they worked. Staff in the Dinnington and Newbiggin Hall areas informed us that they "loved" their jobs and felt supported by their line manager. However, staff in the Gosforth areas did not always feel valued. Comments included, "Morale is low;" "If I left tomorrow they would just think who would cover my calls. They're not bothered about me" and "It's a disheartening company to work for, morale is low."

We spoke with the manager and regional manager about this issue. Following our inspection, the regional manager wrote to us and said, "One to one supervisions are every three months in our new staff management programme and a renewed schedule is in progress with the new co-ordinator [name of staff member] who has experience of working in the Gosforth area and experience of working with staff in this area."

Staff in general told us that they felt that certain working conditions could be improved. The majority of staff were employed on 'zero hours' contracts and did not get paid during their two weeks induction period. They also had to use their own mobile phones and did not receive reimbursement to cover the costs. Staff explained that they did not get any travelling time between home visits. One staff member explained, "I can work 12 hours and just be paid nine because of the time spent travelling." Another explained that they she used her car to travel between visits, but did not get any mileage expenses.

Some people expressed some degree of concern for the staff. They said that some staff appeared rushed and at times seemed stressed. One relative said, "The staff don't stay [at Careline Homecare (Newcastle)] for long because they are not cared for."

We spoke with the manager and the regional manager about these issues. Following our inspection the regional manager wrote to us and said, "Our staff are valued and paid at a very competitive rate, however, improved and visible management of staff and systems are now in place to feedback positively to care workers and to get their views and comments. We hold regular team meetings and supervisions where views are listened to. We have an open door policy; staff are regularly in the office discussing issues with their line managers."

We considered improvements were required to ensure that there was a positive culture within the service and visible leadership.

Staff who knew the regional manager spoke positively about her. One staff member said, "I like [name of regional

Requires Improvement

Is the service well-led?

manager]. She is genuine and she genuinely wants to see things work. When she asks how you are, you know she is being genuine." Some staff with whom we spoke felt that more support from the manager would be beneficial.

Prior to our inspection, we checked all the information we held about the service and saw that they had not sent us notification of people's deaths. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescale. The submission of notifications is important to meet the requirements of the law and enable us to monitor any trends or concerns. We spoke with the manager and regional manager about this issue. Following our inspection, the regional manager told us that she would submit notifications for all required incidents with immediate effect. This issue is being dealt with outside of this inspection process.

We noticed that a number of audits were in place to monitor the quality and safety of the service. These included checks on staff recruitment files, training, supervision and appraisals, staff rotas, medicines management, care plans and records. In addition, continuity of care was monitored. The continuity report showed that the majority of people received high levels of continuity of care.

Over the past 12 months the Branch Reporting System (computerised monitoring system) had been introduced to collect and utilise performance data. However, this system was not fully embedded at the time of the inspection. Once the system was fully embedded the service should have the potential to monitor its systems and processes, more effectively.

We found that although there were systems and processes in place to monitor the quality of the service, sometimes these were not effective in highlighting issues which we had found. In addition, the ECM system was not fully operational and missed calls were not being identified in a timely manner.

This was a breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 9 HSCA (RA) Regulations 2014 Person-centred care Care and treatment was not always delivered in a way that was intended to ensure people's safety and welfare. Regulation 9 (1).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing There were not enough staff employed to meet people's needs. Regulation 18 (1).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not have an effective system in place to fully identify, assess and manage risks to the health, safety and welfare of people who used the service and others. Regulation 17 (1)(2)(a)(b).

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People were not fully protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage medicines. Regulation 13.

The enforcement action we took:

We have issued a warning notice to Careline Homecare (Newcastle) with regards to this regulation.