Care Quality Commission

Taylor Grace Ltd

Caremark (Worthing)

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

The inspection took place on the 5 January 2016 and was announced.

Caremark (Worthing) is a domiciliary care service providing support to people in their own homes. The service supports older people, people living with dementia, people with a physical disability, people with a learning disability, those with a sensory impairment, younger adults and children. At the time of our visit, they were supporting 125 people with personal care.

The service had a registered manager in post who had been registered since July 2015. 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.

All people had care records in place. These showed how people had been assessed prior to receiving support from the service and how current care was planned. When

Summary of findings

risks had been identified for people a risk assessment was put in place. However care plans and risk assessments did not provide the level of guidance required for staff supporting people in their own homes.

People spoke positively about the support they received from the service but also shared frustrations over staff not arriving at the preferred or agreed times, not knowing in advance which staff were attending and on occasions the incorrect numbers of staff arriving for visits. People told us that the agency was short staffed and the staff turnover was high therefore impacted how visits were carried out. We found that the deployment of staff had not ensured people's safety or that their preferences of care times had been upheld.

Medicines were not always managed safely. The records in place did not demonstrate that people had received their medicines as prescribed. Staff administered medicines to people in their own homes in a personalised and professional manner however significant gaps were noted in the records. The registered manager had recognised this issue and had introduced new systems to drive improvements and minimise further risks to people.

Staff felt confident with the support and guidance they had been given during their induction and subsequent training. Staff also told us they were satisfied with the level of support that they were given from the management team. However, staff records showed that supervisions and appraisals were not consistently given to all staff to ensure they were supervised and supported appropriately. The registered manager was aware of this and was encouraging the frequency of spot check visits which included a supervision.

Staff spoke kindly and respectfully to people, involving them with the care provided. Staff had developed meaningful relationships with people they supported. Staff knew people well and had a caring approach. Staff demonstrated how they would implement the training they received. The registered manager had introduced systems to promote good practice. Field care supervisors provided consistency in the delivery of care and a link between the office and people in their own homes.

People had been asked their views on the service provided. People told us that they knew who to go to to make a complaint and how they would do so if required. People had access to contact information in their own homes. Complaints were recorded although it was not clear what the outcomes were, what actions had been taken and what learning had been achieved to improve the service.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have 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 

Some aspects of the service were not consistently safe.

Risk assessments were carried out but lacked the detail required to meet people's individual needs safely.

People's calls were covered but visit times varied from the agreed or preferred times. Some people were assessed as requiring two staff to support them-on occasions but only one staff would have attend the visit.

Medicines were not managed safely.

People said they felt safe and comfortable with staff.

Staff had been trained in safeguarding so they could recognise the signs of abuse and knew what action to take.

Is the service effective?

Requires improvement 

The service was not always effective.

Some staff had not received supervision and appraisals.

People's care needs were managed effectively by a knowledgeable staff team that were able to meet people's individual needs.

People told us that staff attended training and implemented the training they had received.

People received support with food and drink and made positive comments about staff and the way they met this need.

The service made contact with health care professionals to support people in maintaining good health.

Is the service caring?

Good 

The service was caring.

People were supported by kind, friendly and respectful staff.

People's well-being was taken into consideration in the approach used by the staff team.

People were complimentary about the staff and said that their privacy and dignity were respected.

Is the service responsive?

Requires improvement 

The service was not always responsive.

Care plans were in place however lacked the sufficient guidance required.

Summary of findings

People knew who and how to complain however it was unclear of the outcome to the complaint and subsequent actions taken as written documentation was limited.

People told us that staff responded to their changing health and daily needs.

Is the service well-led?

Requires improvement 

The service was not always well led.

People criticised the service for late information given with regards to what staff were attending visits to their homes.

Quality audits had not always effectively monitored and actioned areas that had required improvement.

The registered manager had implemented practices in some areas to improve services delivered to people to minimise further risks.

The culture of the service was open to change and development. People found the service approachable.

Caremark (Worthing)

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 inspection took place on 5 January 2016 and was announced. The provider was given 48 hours notice because the location provides a domiciliary care service, we needed to be sure that someone would be in.

Two inspectors undertook the inspection on the 5 January 2016. An expert-by-experience spoke to people and relatives who used the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An additional inspector interviewed staff by telephone to establish their experiences.

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 Provider Information Return (PIR) and other information we held about the service. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law.

We spoke with 13 people and four relatives to ask them their views on the service. We also spoke with five care workers, one live-in carer and one field care supervisor by telephone prior to the inspection. We received information from the local authority about their views of the service. We used all this information to decide which areas to focus on during our inspection.

On the day of the inspection we visited three people in their own homes and looked at their home care files. We visited the office where we met the registered manager and other members of the team. This included the care coordinator, a field care supervisor who also delivered training to staff and a new care staff member. We looked at five care records, six staff records, staff training and supervision records, medication administration records (MAR), staff meeting minutes, complaints, accidents and incidents record, surveys and other records relating to the management of the service.

The service was last inspected in June 2013 where there were no concerns.

Requires improvement

Is the service safe?

Our findings

People may not have always been protected and kept safe. Care records held at the office on a computerised system showed significant shortfalls in how risks were being assessed and managed. All people had a care record which included any areas the service identified as a risk for that individual. These had been assessed by field care supervisors and then recorded in a risk assessment document. A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details what reasonable measures and steps a service is taking to minimise the risk to the person they support.

One person who was a wheelchair user required support from two staff for all aspects of personal care. A risk assessment had been devised and regularly reviewed yet the rating given by the service was a 'low risk'. There was no guidance for how risks could be minimised when providing personal care by staff; therefore it was difficult to establish how the rating had been given. The same person's care record described additional care needs surrounding needing support with continence care, however there was no associated risk assessment in place to guide staff. A second person's care record highlighted that they were immobile. The care record did not provide details on how staff would support that person with maintaining good skin integrity. Therefore staff members did not receive written guidance on what to do in the event of noticing a pressure sore. It was noted that district nurses were often contacted but was unclear when this involvement was needed. Another person's care record stated, 'Needs two carers', however there was no risk assessment in place for staff to use when supporting that person to move safely. Overall risk assessment records lacked the necessary guidance needed for staff to carry out their role safely when supporting people.

Despite this lack of written guidance staff were observed supporting people safely and people told us that they felt safe. The registered manager was made aware of our findings and agreed that improvements needed to be made to ensure all staff, including new staff received the level of written guidance required to minimise risks to people.

The above evidence shows that risk assessment records were not always accurate and complete therefore potentially placing people at risk. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care plans kept in people's homes and at the office stated the agreed visit times and the length each visit must be in order to deliver the assessed support. Therefore support for each individual was different depending on people's needs. Written care notes were then kept within homecare files and completed by staff at the end of each visit. These notes would be taken to the office at a later date.

Although people received care visits, records showed a variation in when the time of the call was made and people made comments on poor timekeeping. In some instances the actual call time varied considerably from the agreed times in the care plan. One person told us, "I am satisfied but they can be very late." One person's daily notes showed that visits had been consistently late and on one occasion two hours late. Another person's daily notes showed that visits were 30-40 minutes after the agreed times within the care plan. One person told us that their visit times were sometimes later than planned however they did not mind. Some people expressed their concerns for how short staffed the service was and that it was impacting the times staff arrived. One person told us, "They are so understaffed at the moment…they are rushed for time, they should be at the next person when they are still with me". Another person told us that, "At least twice a week it goes wrong and they are very late." We were told that staff being late impacted meal times; one person said, "I am being put on a special diet…and the carers do not come at the right times at the weekend. During the week it is better." One relative told us that if a staff member was late they had to make their family members breakfast as they were diabetic and needed to eat at a certain time. Most people told us that even if staff were late they stayed for the correct length of time and were often complimentary about the care they received, one person said, "They always ask if there is anything else."

Rotas were provided to people providing a breakdown of the following week's support. One person showed us that their rota that had been sent to them. Half the visits had not been allocated with a name and they commented, "Half the time it changes anyway". Some people told us

Is the service safe?

that they were informed late, or, not at all regarding which staff members were attending their home visit. Therefore people could not rely on the rota for accurate information about who would be assisting them.

Some people were assessed as requiring two staff to support them but on occasions only one staff would attend the visit. One relative explained that their family member had been assessed as needing two staff at each visit and on four days last week only one had come. They said, "I only feel [named person] is safe when two come as it should be. I get anxious and feel that I have to offer support". Another person who required two staff for moving and handling told us, "Some of them do it by themselves that's when they are short staffed". The same person complimented the staff for the good work that they did but expressed that they were coming in the evening too early and not at their preferred time. We read care plans where people had been assessed as requiring two staff for visits and gaps were noted in daily records to confirm that two staff had been present. Therefore it appeared in people's daily records that only one staff member had carried out care that required two.

The registered manager was open to a discussion regarding staff deployment and explained how field care supervisors limited the risk to people and covered sickness and other rota gaps. The registered manager shared difficulties in the past with regards to recruitment, however felt confident that there had been an increase in staff employed to meet the needs of people they supported. The registered manager provided information including timesheets after the inspection that showed that the majority of the recording gaps noted for people that required two staff to support them, had been recorded elsewhere and was therefore a clerical issue. Therefore there was some assurance that two staff had attended appropriately although the daily records differed from this. Staff meeting minutes dated 12 October 2015 explained to staff the importance of maintaining accurate records. The registered manager was also aware that one person who required two staff to support them had experienced only one staff attending visits in in the past but this had now been rectified and there had been no recorded issues since September 2015 and said "It's completely unacceptable." The registered manager told us that problems were minimised with, "Constant communication with customers who have double up calls". When we spoke to staff they told us that they would not carry out support if the other staff member failed to turn up and would contact the office or the field care supervisor. Staff also said travel time between visits was not enough and led to late appointments with people. The registered manager said, "Carers should know not to enter the property until the second carer arrives". The registered manager had commenced telephone monitoring calls to people and regular memos to staff to support improvements in this area and told us, "I want everyone to be safe."

The above evidence showed that there was not always sufficient numbers of staff deployed to meet peoples assessed needs, therefore posing a risk to people's safety. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people received support from staff with their medicines. We observed staff administering medicines to people in their own homes in a personalised and professional manner. People did not express concerns over how staff supported them with their medicines. We found, however records of medicines administered or prompted did not demonstrate that people had received their medicines consistently as prescribed by their GP. Medication Administration Records (MAR) were completed by staff and stored in each person's care file in their home. People's MAR were later given in to the office which meant there may be some delay in these records being quality assured for accuracy.

People's MARs contained significant gaps, lacked information to the reasons a particular medicine had been prescribed and lacked details in the times that medicines (including creams) were to be administered by staff to people. One person's MAR made no reference to what time staff were to administer one medicine however stated a general 'AM' and 'PM'. The same MAR for August and September 2015 had 21 gaps where no signatures had been made by staff. There were no entries made by staff on the MAR to provide an explanation as to why that medicine had not been administered. Another person's MAR had unexplained gaps and the medication plan was last assessed on the 29 October 2013. A third person's MAR had been completed with signatures, however it was unclear what medicine was being administered and when. More recent MAR from October 2015 remained in people's homes so the registered manager was unable to ensure the quality and clarity of medicines records for the proceeding three months. Therefore the records and information available

Requires improvement

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related to people's medicines did not provide sufficient guidance about the medicines people were prescribed and how they were to be given. The MARs did not provide confirmation that people received their medicines as required. Therefore people were at risk of not receiving their medicines safely.

The evidence above showed that the proper and safe management of medicines was not always followed. The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was already taking action in this area as the risk to people had already been identified. Some staff had already attended further training and practices were being addressed. Memos and staff meetings had highlighted the concerns and reinforced the need for records to be completed at the time of administration of medicines to people. The internal trainer provided us with a copy of their new medication workbook that staff were completing. Practical medication competency assessments were undertaken by staff and held within staff records. A new staff member told us of the practical competency assessment they had completed. Another staff member told us that they had received a mix of online and face to face training and said, "I think it prepares us to do it safely." The registered manager showed us a 'medication alert form' that staff were encouraged to complete and acknowledged the need to improve further. The registered manager demonstrated their understanding of the importance of managing medicines safely by seeking advice from the safeguarding team and the Care Quality Commission with regards to a recent incident.

People confirmed that they felt safe when staff were in their homes and we observed people looked at ease with the staff that were supporting them. One person said, "I feel safe with them all". When asked if they felt safe with staff another person told us, "Very safe". A third person told us, "They are all very careful". One relative described difficulties they experienced with their family member and commented that they felt much safer when the staff arrived. One person who required two staff members to support them with personal care told us, "I feel safe when people help me; they know what they are doing".

Staff recruitment practices were robust and thorough. Staff were only able to commence employment upon the office receiving two satisfactory references, including checks with previous employers. In addition staff held a current Disclosure and Barring Service DBS (DBS) check. Certificates of qualifications staff had listed on their application forms were held on file, this showed that the authenticity of qualifications had been established. Recruitment checks helped to ensure that suitable staff were supporting people safely within their own homes.

Staff understood the need to protect the people they supported and told us that they had received regular safeguarding adults at risk training. Staff that supported children in their homes attended child protection training which was confirmed by staff training certificates. Staff members told us that they felt confident in recognising signs of possible abuse and understood their duty of care to report any concerns they had. Staff could tell us the importance of reporting all concerns to the office and that they received regular support from field care supervisor whom they could contact at any time. Staff also knew how they could escalate an incident to external professionals including the local safeguarding team. Staff explained that any changes to people's care were sent from the office via a secure email system. This included changes in health and behaviours which encouraged effective communication and helped reduce the risks for people and staff.

Requires improvement

Is the service effective?

Our findings

The service had a supervision and appraisal system in place for staff that supported them in their roles. Staff talked positively about the supervision they received particularly from a field care supervisor. The supervision policy described that all staff should receive supervision sessions throughout the year and one appraisal, with spot checks and observations in practice in addition. The 'care and support worker handbook' that was provided to all staff read, 'you will receive regular supervision' and 'supervision will be replaced once a year by a care and support worker review'. The field care supervisor told us that supervisions were given to staff every two months and these meetings would be held at the office or a coffee shop. However we found that records could not be produced to confirm this in every case and supervisions of staff were not occurring at the planned frequency.

One staff member had received a spot check visit and observation in October 2015 however prior to that no record of a supervision since 2013. Records showed that two staff members had not received supervision throughout 2015. In addition out of the staff records we checked only two staff had received an appraisal from their line manager. A system of supervision and appraisal is important in monitoring staff skills and knowledge therefore this meant that staff were not always receiving effective support. Given the concerns we identified in relation to timeliness of care visits and record keeping, a robust system of supervision and checks on staff practice would have been useful in identifying and addressing these concerns. The registered manager was aware of the gaps within supervision records and the lack of appraisals. She told us, "They don't happen as often as I like due to prioritising and to carers availability". Therefore staff did not consistently receive the support and supervision they required to carry out their duties and ensure their competence.

The above evidence shows that staff did not always receive appropriate supervision and appraisal necessary to enable them to carry out the duties they were employed to perform. This is a breach of Regulation 18 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where supervision meetings had taken place they tended to be after spot check visits, actions were recorded and carried over to the next meeting. Spot check visits were a monitoring system that included discussions with people and how they found the care they had received. The registered manager also told us that one of their aspirations was for supervisions and appraisals to be completed more frequently and at the office. An email from the registered manager to all staff dated 20 November 2015 made reference to all staff being invited to attend an appraisal. One staff member who had received spot checks, supervisions and an appraisal told us, "They check everything, from the time you arrive onwards. They use it for one to one supervision afterwards, it is supportive. We get an annual appraisal and the office is open to go to any time". Another staff member described their supervisions as an opportunity to discuss any issues surrounding the people they supported and their own training needs.

People received support from staff that had been taken through a thorough induction process and attended training with regular updates. Most people told us that staff were trained and knew how to meet their needs. One person told us, "They are all good at their jobs"; another said "I am sure they have been given training". However one person did say, "My regular was trained but some of the others not at all".

All new staff completed a service induction checklist process which covered all aspects of their role. New staff were also completing the Care Certificate (Skills for Care) which covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment. During the induction period new staff shadowed more experienced staff. This meant staff learnt how to support people correctly and understand their needs. Records showed that mandatory training for all staff was consistent and regularly updated. There were 14 topics covered including dementia, safeguarding adults and food hygiene. The internal trainer shared workbooks that staff completed. These covered first aid and moving and handling involving practical competency assessments which staff completed observed by the trainer. Training packages were developed when a staff member required a certain skill. For example safeguarding children training was provided for staff who supported children.

The registered manager shared a training matrix with us. This showed that 14 staff out of 46 had achieved Health and Social Care Diplomas. These are work based awards that are achieved through assessment and training. To

Is the service effective?

achieve these qualifications, candidates must prove that they have the ability (competence) to carry out their job to the required standard. The registered manager was encouraging other staff members to achieve this award.

Team meetings had taken place. Topics covered included Medication Administration Records (MAR), Timesheets, Sickness and Rotas'. Team meetings were seen as an opportunity to offer additional support to the staff whom often lone worked in the community.

Staff told us they were satisfied with the training they received. One staff member shared that they had completed training and annual refreshers on line. They also said that outside speakers had been arranged to cover topics such as epilepsy and asthma. Another staff member said, "Training has been very good. Annual refreshers are always on time and they won't let us miss them. We have special training sessions, like if there's a new piece of equipment we need to know about". A third staff member described additional training they had received as they supported a person diagnosed with autism. Staff felt they could approach the field care supervisor or the office if they required additional training. For example one staff member had requested they receive training about children with hearing difficulties. This enabled training packages to be personalised in accordance with the care and support required. Documents were attached to staff meeting minutes to provide further learning opportunities. For example staff meeting minutes on the 12 October 2016 included information about the Mental Capacity Act. We were able to see staff implementing their training when supporting people. For example when observing staff supporting people who had moving and handling needs they did so with confidence. Therefore the training and guidance staff were provided from induction to refresher training equipped them with the skills and knowledge to understand and meet people's needs.

When we visited people in their own homes we observed that staff involved them in decisions and choices. Consent to care and treatment was sought in line with legislation and guidance. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as the least restrictive as possible. People were involved in making decisions relating to care and treatment and staff received training on the topic and understood how consent should be considered. Field care supervisors were trained in assessing mental capacity and we found staff to have an understanding of the Mental Capacity Act (MCA). The registered manager provided forms which would be completed with regards to capacity by field care supervisors if a person's needs changed. Staff told us that they would seek guidance from the field care supervisor if a person's need changed. The registered manager told us they would approach the relevant family member and/or a health and social care professional if changes in capacity for people were highlighted.

Some people's needs had been assessed with regards to what support they required with food and hydration. Others were able to support themselves or received support from family members. Ten people told us about the support they received with meal preparation as it was part of their care package. Mainly people were very happy with the support they received with their meals. All concerns expressed were relating to the impact when staff were late. People told us that they were able to choose what they liked to eat. One person said, "Oh yes I have options" and another said, "I choose from the frozen meals in the freezer". One person told us, "They all make tea and sandwiches, they always wear gloves and they clear up afterwards". We observed staff involve people in what they had to eat for breakfast using a personalised approach. Staff told us that they had enough time to support people and that there was information in people's care plans about people's needs. One staff member who supported people to eat told us, "I would never leave a person with an unfinished meal, would ring the next person if I was going to be late as its important people eat well and are not rushed". Another staff member said, "All of us see it as important to give people the time they need for meals, it should be social thing as well as the need to eat enough of the right things".

People felt confident that staff could manage healthcare needs. The support provided would vary depending on a person's needs. Where healthcare professionals were involved in people's lives, this care was documented in the care plan. For example, we noted that district nurses were involved with some people's care. The field care supervisor told us they encouraged staff to call district nurses when a need arose and recorded any actions and outcomes from

Requires improvement

Is the service effective?

the appointment. The registered manager and staff told us that rotas given to all staff included key notes. The key notes reported any healthcare changes to people they may be visiting. One staff member told us, "We get texts and phone calls with updated information about clients". The same staff member explained that they would liaise directly with healthcare professionals if people's needs changed. One staff member had, with support from the office, contacted one person's social worker as their mental health had deteriorated showing that they were able to take the necessary action to keep that person safe. The registered manager encouraged staff to provide updates to the field care supervisors and the office in order to maintain people's good health. The registered manager maintained links with local healthcare professionals and sought advice when needed to ensure people's needs were met.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. Staff had a caring approach and were patient and kind. Staff smiled with people and looked approachable; their interactions were warm and personal. One person told us, "The carers are very good". Another person who had been receiving care from the service for five years told us, "I love them all" when referring to the staff.

We observed three people supported by staff in their own homes. Laughter was heard and where appropriate 'jokes' were exchanged. One person required two staff members to attend each visit for support with all moving and handling. Staff were heard checking that the person was comfortable with how they were being supported, "Are you comfortable?" and "Are you ready for your breakfast now?" It was clear that the staff knew people well, how they liked their support to be given and their interests. Staff used their preferred name and engaged with conversations about people's family members. One person showed us photographs of their family members and when they forgot the name of the person they were showing us the staff member providing support were able to interject and provide the name. One person said, "They even open my banana for me". Another person told us, "They understand me, they understand what I need, they are jolly".

People also confirmed their positive experiences of the staff team including the field care supervisors when we spoke to them over the telephone. One person said, "They are helpful, polite, they do their best to help me". One relative described the staffs rapport with their family member as being, "So good and caring and [the named person] gets on well with her. Because of this I employed her through Caremark, for extra hours". Another person who received support told us, "The carers are lovely" with another stating, "they are lovely girls, I'm very lucky". Another person said, "They are always nice to me and very willing". A person that had used the service for many years said, "very good care" and repeated several times, "They are all very good". A person who had recently started using the service told us, "They are very genuine people". However one person did say, "some are most helpful: some are better than nothing."

People were encouraged to be involved with the care and support they received. We observed staff involving people in their day to day decisions surrounding their personal care and meal preparation needs. People seemed to be aware of the contents of the blue daily files that were kept in their homes. These included contact information, their care plan and other daily monitoring forms. People were given opportunities to make comments to the service and review their care. People were asked questions by field care supervisors during spot check visits of how they found the care they received. People were able to make decisions about the times of visits and whether they preferred male or female staff to attend. One relative said, "It is nice for [named person] to have a man to help sometimes".

People were supported by staff who promoted and respected privacy and dignity. We observed staff members were sensitive when supporting people. One person required support from staff using a hoist for moving and handling, we heard staff say, "You are going to go up now," and, "Now you are turning". We observed one staff member adjust with permission a person's skirt as it had been raised during the support provided. Staff continuously checked with the person whether they were happy with what was happening and gave them time and the opportunity to respond. One person used to receive support from staff however told us that, "They do not do my food anymore, they helped me to become independent and now I can do it". This showed that people were encouraged to be as independent as possible. People told us that even though they were not always informed which staff were attending the visit and sometimes people were late it would be staff that they knew already.

The service worked hard to promote continuity in the care it provided by regularly sending the same and preferred staff on visits to people. Staff told us that the allocation of staff to people was considered during rota planning. Seven staff told us that they usually supported the same people unless they were covering. One staff member told us, "I work mainly with the same people. Three of us cover each other, so we know the people well". This helped to develop trusting relationships between people and staff. They also shared, "Its important personal care in someone's own home is such a personal thing, they don't want different people coming in." We noted that privacy and dignity training had been completed by some staff as recorded in staff records at the office. One staff member told us, "Even when it's just me and the client in their home, I ensure I cover them up at each stage of care and keep alert to closing doors and curtains".

Requires improvement

Is the service responsive?

Our findings

Our observations indicated that staff knew people well and responded to people's needs in an individualised and caring way. We found, however care plans failed to document needs clearly as they lacked the detailed guidance required. Care plans were kept for each person at the office and written in the first person. They stated the planned areas of care however did not provide instructions for staff on how to carry out each area of care. Care plans lacked descriptions about people and the impact their diagnosis may have had on the way they needed their care delivered. They were inconsistent when explaining individual preferences of people and whether a person was able to consent to the care provided. For example one care plan told us information about what a person had achieved when they were younger, this including their past career. The same care plan told us that the person was now living with dementia and read, 'I will need assistance with bath time', yet no information had been provided in how that person would like to be supported with a bath therefore no consideration had been given to the current needs or personal preferences of that person. Another person required two people to support them. Their care plan read, 'To have my personal care needs met', however no information provided on how the person would like to receive personal care or what aspect of personal care the care plan was referring to. A third persons care plan stated, 'assist me with my medication', yet no guidance on whether that was prompting with a person's medicine or administering the medicine to them. Other inconsistencies with care plans were noted this included the frequency of when they were reviewed. This may have impacted how care was provided to people by new and existing staff.

The information in the care plans in the office were then transferred into the care records kept in people's homes. These also included daily monitoring forms that staff had to complete, including daily logs at the end of a visit. We received mixed feedback from people with regards to their thoughts on care plans. Most people were unable to say how often care plans were reviewed. One person told us, "Sometimes the supervisor comes to talk to me to see if the plan is reasonable". One relative reported that they had written the care plan, "they went through it and it was agreed". Two people shared that staff did not have sufficient time to read the care plan in their home yet another person thought their care plan was checked throughout the year. We observed staff reading and using the care records in people's homes.

We discussed the care plans and our findings with the registered manager and they told us they were aware that there were issues with some care planning. They explained that this had been fedback (to the provider) and the care plan formats were in the process of being reviewed. The registered manager agreed that care plans needed to be developed and said, "There should be more details". Therefore people were at risk of their care needs not being understood or met because the records related to their care were not complete or fit for purpose.

The above evidence showed that care records lacked accuracy and were incomplete. This is a breach of Regulation 17 of the health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service responded to changes in peoples care needs. Staff and a field care supervisor told us that any changes to care highlighted on visits were regularly communicated back to the office. The registered manager and staff told us that this information was then included with the key notes sent to staff with their rotas for the following week. The registered manager told us that secure texts and emails were sent to staff if items needed a faster response and staff confirmed that this happened. When people's needs changed external health professionals were contacted and the healthcare need was addressed and notes were made in care files. One staff member told us of an example when a persons need did not match the information in the care plan. On this occasion the field care supervisor was contacted and the care plan was amended. Therefore staff were involved in updating care plans with current information.

There was a complaints policy in place. People were provided with names and contact telephone numbers of who to contact in the event of needing to make a complaint. These were made available to people in their own homes. The field care supervisor was usually the first point of contact for people when complaints had been made, however, people and relatives also contacted the office. The service had a system to gather the views of people, relatives and staff. The last annual review for people had been completed on the 16 March 2015. This was a 'customer annual survey analysis', 142 surveys had

Requires improvement

Is the service responsive?

been sent to people, 47 surveys had been received and analysed. The main complaint noted from people was surrounding call times being changed more often than usual however there was a strong satisfaction and appreciation with the support provided from care staff.

A record of complaints was kept; we saw evidence of this within care records and a separate complaints file. Mainly people told us that their complaints related to poor timekeeping and this was evidenced within the care plans we read. The field care supervisor confirmed that this and the changes to the rota were the most common complaints. Records showed that the service had responded to concerns raised. However it wasn't clear what the outcomes were for people who raised the complaint.

This included whether the complaint had been resolved and what actions the service had taken and if any feedback had been provided to the person. Therefore any learning the service had taken from the incident was difficult to assess. The registered manager could tell us the actions they had taken and the responses they had provided to people however failed to document them clearly. For example they shared their response to one complaint from a relative but failed to record how it had been resolved to evidence this. **We recommend that the provider reviews its systems for recording the outcomes, actions and learning with regards to complaints received including how they feedback to people.**

Requires improvement

Is the service well-led?

Our findings

People expressed mixed opinions on how they found the service as a whole. Some people were frustrated with poor timekeeping and not knowing which staff would be attending their visits and this dominated how they viewed the office and how it was organised. Others were very appreciative of what the service had achieved for them. People were able to share positive experiences of how they had been supported and found staff to be caring in their approach. Some people would recommend the service to others.

There was a registered manager in post at time of inspection. The registered manager shared the last 'customer annual survey analysis'. The date it had been carried out was 16 March 2015. This provided opinions of 47 people who used the service. This cited that there was a, 'Very strong satisfaction and appreciation of care and support received'. Further comments included, 'Concerns over continuity of care' and 'Concerns over number of changes in call times'.

There was a system in place to check records that were held in the service. A quality assurance service check from the provider had taken place on the 9 April 2015. This had reviewed care and staff records to establish whether necessary documents were in place. The quality assurance check found the service to be compliant. However it was unclear how the effectiveness of the care records and risk assessments had been reviewed and evaluated at that time as we found concerns with record-keeping and robustness of care records at this inspection.

The registered manager told us that they were aware of the areas of service provision that required improvements including medicines management, timeliness of care calls and clarity of care plans. They shared some actions that they had already taken. Particularly with regards to how medicines were recorded and increasing the frequency of spot check visits to people's homes. However there was no current action plan in place which provided information on how the quality and safety would be improved for people using the service. Monitoring tools had identified issues as the registered manager was able to tell us steps they had taken to improve care delivery yet it was not clear what had been achieved, when and by whom. For example; the registered manager recognised the need for regular supervisions for all staff but had not recorded a review of how this would be achieved. Therefore although there were processes to identify areas for improvement, this had not always been used effectively to implement the necessary changes in a timely way.

The above evidence shows a failure to monitor and improve the quality and safety of the service for people. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014.

The registered manager told us they had received feedback that people did not know who they were and said, "They [people] don't know who the manager is". Therefore was keen to develop and maintain relationships with people that the service supported. They shared this was the driving force behind the introduction of telephone monitoring calls with people who use the service. The registered manager aimed to hold telephone calls with people to establish further feedback on they they viewed the service.

We spoke with a representative from the local authority who had visited the service recently. They made positive comments about the service and said, "They have good communication and respond well to queries". The registered manager was enthusiastic when discussing what they had been involved with since they had been in post and spoke passionately about the vision they had for the service. "I always believe there is room for improvement".

The registered manager provided supervision to field care supervisor's therefore ensuring links were maintained with people and staff. This enabled the culture of the service to be open and provided opportunities to ensure people who received care were being listened to. Staff told us they were happy with the service and the way it was managed. One staff member said, "The company is very efficient". They also shared that, "[the registered manager] is brilliant". Another told us, "There are regular staff meetings we have to attend". A field care supervisor saw the service as well led and told us, "Sees management as focussed on quality, confident they are supportive". The registered manager told us that they valued the staff team and shared how they and the provider were looking at ways to retain the current team. This included reviewing rates of pay and encouraging staff to undertake further qualifications.

The registered manager told us that they had put on hold accepting new service users so that they could take the

Requires improvement

Is the service well-led?

time to improve on the areas highlighted. The registered manager was committed to the people that use the service and told us that, “The most important thing is that they are happy with their care”.

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 17 HSCA (RA) Regulations 2014 Good governance **The provider had not ensured that risks were effectively assessed, monitored and mitigated. There were ineffective systems or processes to assess, monitor and improve the quality and safety of the services provided. The provider had not maintained complete and contemporaneous records in respect of each service user.** **Regulation 17 (1) (2) (a) (b) (c)**

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **The number of staff deployed was insufficient to meet people's needs.** **Regulation 18 (1)**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Medicines were not safely managed.** **Regulation 12 (2) (g)**