Medacs Healthcare PLC

Medacs Healthcare - Croydon

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**

Summary of findings

Overall summary

Medacs Healthcare - Croydon is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults, and children. At the time of our inspection 503 people were receiving a service. Approximately 50 of these were younger people under 18 years old. Personal care was not provided to this group and therefore we did not look at this aspect of the service at this inspection.

Medacs Healthcare – Croydon provides home care across a number of London Boroughs. This includes long term domiciliary care packages as well as short term reablement packages and support to people receiving end of life care in their own homes.

At our last inspection in December 2015 and January 2016 we rated the service 'good' overall and for each key question. At this inspection on 6 & 7 March 2018 we found the service's rating had deteriorated to 'requires improvement'.

Since our last inspection a new registered manager had been appointed in January 2018. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

There were not sufficient numbers of staff to meet people's needs. We heard occasions of missed visits or only one staff member attending when two staff were required to keep people safe. Scheduling difficulties meant people often experienced late calls and at times people felt staff were rushed to get to other appointments which impacted on the quality of care provided.

Staff told us they had good access to training opportunities, however, the training matrix showed staff were not up to date with their annual refresher training. Staff received regular supervision and annual appraisals.

People told us they were supported with their medicines, however, accurate medicines administration records were not always maintained. The service quality assessors and in-house trainer were working with staff to help improve the quality of medicines records.

Staff were knowledgeable about the risks to people's safety and how these were to be mitigated, and staff followed safeguarding adults' and children's procedures. Staff followed best practice in regards to infection control.

Staff provided people with any support required with nutritional, hydration or health needs. Staff adhered to the principles of the Mental Capacity Act 2005.

People were complimentary about the support they received from their regular care workers and the caring relationships they had built with them. Staff assessed people's needs and detailed records were maintained about how people wished to be cared for. Staff were respectful of people's privacy and dignity, and supported them to maintain, and regain where possible, their independence. People were empowered to make choices about their care and staff were aware of any sensory impairments people had which impacted on their ability to communicate their choices.

A complaints process was in place. We heard that previously people felt their complaints were not listened to and responded to in a timely manner, however, we also heard that this had much improved recently.

The management team had recently been restructured to provide stronger management and leadership across all areas of the service. The management team had regular meetings with the local authorities they had contracts with to ensure consistent and coordinated care.

The provider's quality monitoring processes had identified areas requiring improvement and new systems had been introduced to address some of these concerns, including in relation to scheduling and out of hours arrangements. It was too soon to assess the impact of these new systems and we will look at this at our next inspection, but staff had been gathering regular feedback from people to ensure the changes were making a positive change.

The registered manager adhered to the requirements of their registration including submission of statutory notifications and displaying their inspection rating.

The provider was in breach of legal requirements relating to staffing. You can see what action we have asked the provider to take at the back of this report.

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 safe. There were not sufficient numbers of staff to meet people's needs. We heard occasions of missed visits or only one staff member attending when two staff were required to keep people safe.

People told us they were supported with their medicines, however, accurate medicines administration records were not always maintained.

Staff were knowledgeable about the risks to people's safety and how these were to be mitigated, and staff followed safeguarding adults' and children's procedures. Staff followed best practice in regards to infection control.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective. Staff told us they had good access to training opportunities, however, the training matrix showed staff were not up to date with their annual refresher training. Staff received regular supervision and annual appraisals.

Staff provided people with any support required with nutritional, hydration or health needs. Staff adhered to the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. People were complimentary about the support they received from their regular care workers and the caring relationships they had built with them.

Staff were respectful of people's privacy and dignity, and supported them to maintain, and regain where possible, their independence. People were empowered to make choices about their care and staff were aware of any sensory impairments people had which impacted on their ability to communicate their choices.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive. Scheduling difficulties meant people often experienced late calls and at times people felt staff were rushed to get to other appointments which impacted on the quality of care provided.

Staff assessed people's needs and detailed records were maintained about how people wished to be cared for.

A complaints process was in place. We heard that previously people felt their complaints were not listened to and responded to in a timely manner, however, we also heard that this had much improved recently.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led. The management team had recently been restructured to provide stronger management and leadership across all areas of the service.

The provider's quality monitoring processes had identified areas requiring improvement and new systems had been introduced to address some of these concerns, including in relation to scheduling and out of hours arrangements. It was too soon for us to assess the impact of these new systems, but staff had been gathering regular feedback from people to ensure the changes were making a positive change.

The management team had regular meetings with the local authorities they had contracts with to ensure consistent and coordinated care.

The registered manager adhered to the requirements of their registration including submission of statutory notifications and displaying their inspection rating.

Medacs Healthcare - Croydon

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 6 & 7 March 2018 and was announced. We gave the service two working days' notice of the inspection visit because it provides a domiciliary service and we needed to be sure they would be in. The inspection was undertaken by two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed the information we held about the service, including statutory notifications submitted about key events that occurred at the service. We also reviewed the information included in the 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 also sent questionnaires out to people receiving a service, their relatives, staff and community professionals to obtain their views and feedback about service delivery. We received completed questionnaires from six people, six relatives, 11 care workers and three community professionals.

During our visit to the office on 6 March 2018 we spoke with nine staff including the regional operations manager, the registered manager, the care manager, the quality manager, a team leader, three care co-ordinators and an administrator. We looked at eight staff records including recruitment processes. We also looked at records and electronic systems related to the management of the service, including scheduling programmes, spreadsheets to monitor supervision, field observation and staff training, staff meeting minutes, findings from satisfaction surveys, policies, service user guides and staff's code of conduct. We also

looked at 42 people's care records.

On 7 March 2018 we spoke with 27 people or their relatives and eight care workers via telephone.

Over the course of the following week we spoke with an additional three staff, including the provider's in-house training and two service quality assessors (SQAs), and received feedback from 12 care workers, one relative and representatives from two local authorities via email.

Requires Improvement

Is the service safe?

Our findings

The majority of people felt safe receiving care from Medacs Healthcare. Comments from people and their relatives included, "I have lived here for 30 years in the same block, so this makes me feel comfortable and we have had the same carers", "Yes I feel safe and happy with them", "Yes, I do feel safe and this is very important to me as I am partially sighted" and "Mum is as safe as she can be, and she really likes the carers and feels safe".

Despite the comments above we received feedback from many people and/or their relatives that indicated there were not sufficient numbers of staff to meet people's needs. We received feedback that people experienced missed visits, that only one care worker turned up when two were required, that care staff were frequently late and that people did not always receive support from a regular care worker. The comments we received included, "They send me a different [care worker] every day. When I call and say please give me a regular [care worker] they say they can't as they are short staffed", "It is the first visit in the morning that is the real problem. They arrive anywhere between 09.20 to 10.00am. We had agreed at the beginning it would be 08.30am. I like to go to the church in the mornings and I can't now because of their lateness. I told them in the office but they said they can't come at 08.30am due to their rotas", "Now there is only one care worker as opposed to two", "They are often at a different time than I expect and I have had two missed calls this week. They are always in such a rush because they are given too much to do" and "They are often very late, last week the 10.00am visit was at 12.00pm although it is more often at 11.00am. They have missed me out altogether too."

This feedback was also supported by the care workers we spoke with. One staff member said, "I do believe they have been finding it difficult to have enough staff both in the office and out in the field. This puts pressure on the carers already working. I really don't know but still feels like not enough staff. Not enough staff to cover all the calls."

The registered manager confirmed they were undertaking ongoing recruitment due to the planned expansion of the service, although they confirmed they found recruiting people with the right skills and experience challenging. This included recruitment of additional care workers, care coordinators, SQAs and administrators. At the time of inspection there were eight office staff vacancies as well as care worker vacancies.

The evidence above shows the provider was in breach of regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

We checked the recruitment documents for recently recruited staff and saw that safe recruitment procedures were followed. This included checking staff's identity, their eligibility to work in the UK, obtaining references from previous employers and undertaking criminal records checks.

On the whole the feedback we received was that people who required it were supported to take their medicines as prescribed. A medicines assessment was completed by the SQAs which instructed care

workers about the level of support people required in regards to medicines administration. It was made clear as to whether people required prompting to take their medicines or required full support from staff with administration of their medicines. The medicines risk assessments also informed staff what the medicines were for, the potential side effects and the impact of under or overdosing of the medicine. Instruction was provided to staff about how to administer medicines and for topical creams where they should be applied and how often. However, we saw varying levels of completion of medicine administration records (MARs). Many of the MARs we viewed at the office had gaps and it was unclear as to whether the medicines had been administered or not. The SQAs had identified as part of their checks that the quality of the MARs varied and that improvements were required. Where improvements were identified as required the individual care workers were provided with additional support and guidance during observations and were asked to complete refresher medicines management training. The registered manager told us they would continue to support staff to improve the completion of MARs.

Staff were knowledgeable in recognising signs of possible abuse and were aware of the reporting procedures to follow in order to protect people from any additional harm. We saw the management team escalated concerns appropriately to the local authority safeguarding adults' teams so additional investigations could be undertaken when necessary. This included reporting any allegations of abuse as well as any missed visits which impacted on people's health and welfare. Staff reported allegations of abuse to the Care Quality Commission as required so we could monitor the action taken to keep people safe. From records we saw the management team cooperated with investigations being undertaken by the local authority safeguarding team and implemented the advice provided.

From records we saw full risk assessments were undertaken at the start of each person's care package. The SQAs visited people using the service within 48 hours of the package starting to undertake a full assessment, this included discussion with the person, consulting the information provided by the local authority placement team and liaison with any relevant healthcare professionals. We saw risk assessments included identifying risks associated with the environment, fire safety, management of clinical waste as well as in relation to any individual clinical needs. These assessments were detailed and referenced any sensory impairment or behavioural trait people had that impacted on the risks to their safety or on their risk behaviour. Plans were developed detailing how care staff were to support the person and mitigate risks. This included information about how many care workers they required support from and in relation to moving and transferring, as well as any equipment people used to assist with transferring. Information was also included about any weaknesses or pain people regularly experienced which impacted on moving and handling techniques. People's risk management plans were regularly reviewed and updated in line with any changes in people's care needs.

There were clear polices and processes in place instructing staff what to do if an incident occurred. This included in the event of a medical emergency as well as if staff were unable to gain access to a person's house and were unable to locate the person. One care worker told us, "If I have any concern and I raise it with my coordinator, she will take it up and give me feedback and if she cannot, she will connect me with someone that can help."

Staff protected people from the spread of infections. Staff had access to personal protective equipment (PPE) and care workers, people and relatives confirmed that PPE was worn when supporting people with their personal care. Staff were aware of good hand hygiene procedures. During observations of care workers practice the SQAs checked staff were adhering to infection control procedures, including wearing PPE and safe disposal of clinical waste.

Requires Improvement

Is the service effective?

Our findings

Staff felt well supported during their induction. One staff member said, "They've eased me into the role…I feel able to ask questions and they answer all my questions." During induction there were knowledge and competency based checks. Staff shadowed more experienced staff and were supervised by the SQAs before being assessed as competent to undertake their duties unsupervised.

All the staff we spoke with were pleased with the training delivered and felt they were provided with opportunities to develop their knowledge and skills. One staff member said, "Training is very good, I've just completed end of life care training and it's very important." Another staff member told us, "There's always refresher training." A third staff member said, "They train staff well and make sure we treat our clients the best way possible too. They have good training to better the skills of us workers." However, we received conflicting information from people and/or their relatives about the skills of their care workers. One person said, "Yes. They are very good - all three of them [care workers]. They are well experienced." Whereas other relatives said, "There have been times when they have sent carers who don't know how to care for my wife, she has a stoma and they have never seen one before" and "Yes [we are happy] with our regular carers but not otherwise, my wife is in a wheelchair and has a stoma and there seems to be no attempt to ensure carers with the right expertise are sent". We also received concerns from one local authority about staff's knowledge and training around moving and handling, particularly in regards to the use of hoists.

The service's in-house trainer told us about the training on offer and there was an annual programme for mandatory training including; safeguarding of vulnerable adults, safeguarding children & young adults, food safety and hygiene, dementia awareness, fire safety awareness, health & safety including risk incident reporting, infection control, information governance, data protection, handling patient information, record keeping, lone worker, continence care, catheter care, epilepsy awareness, diabetes awareness, and end of life and palliative care. However, from the provider's mandatory training matrix we saw that not all care workers were up to date with their required annual refresher training. 54 staff had not completed training in medicines management, 74 staff had not completed moving and handling training, 123 had not completed safeguarding adults' training, 108 had not completed basic life support training, 128 staff had not completed health and safety training and 111 had not completed food hygiene training. The registered manager told us they had gone for a period of time during 2017 without access to an in-house trainer and this had impacted on the delivery of the mandatory training programme. However, this was now being addressed and a permanent in-house trainer had been recruited. Staff were clear that if they did not stay up to date with their mandatory training they would be taken off care delivery until they updated their knowledge and skills.

Nevertheless, at the time of inspection the provider was in breach of Regulation 18 of the HSCA 2008 (Regulated Activities) Regulations 2014.

Staff had received training in specialist healthcare needs if they were supporting people that required this level of support, for example in regards to ventilators and for people with tracheostomies. Whilst care staff did not provide treatment to people with these needs the training enabled them to identify if there were any concerns or signs of infection so additional support could be sought.

Staff provided people with any support they required with meals and access to drinks. People's care records detailed what level of support they required and information regarding any food allergies or specific dietary requirements. Staff told us they always checked whether people had eaten and that they had access to drinks throughout the day. They said they offered to make a person a hot drink when they were visiting particularly if the person was not able to access their kitchen and hot water safely. The daily records staff kept detailed the support provided with nutrition and hydration so this could be tracked and monitored.

We received mixed feedback from people about the level of support staff provided them with access to healthcare services. However, from discussions with staff and review of daily support records we saw staff liaised with healthcare professionals appropriately when they identified that people's health was deteriorating. This was also communicated with people's relatives so they were kept informed about any changes in people's needs.

For people receiving a rehabilitation service staff had close working relationships with the other professionals involved in the person's care including physiotherapists and occupational therapists. Multi-disciplinary meetings were held to review people's care needs which staff from Medacs healthcare attended to provide a holistic, consistent and coordinated approach towards people's care.

Staff were aware and adhered to the Mental Capacity Act 2005. Care records clearly indicated if a person had the capacity to consent to care and if they did not have the capacity to consent, what decisions they were unable to make and who staff were to liaise with in order to assure decisions were made within people's best interests'. Staff told us they communicated with people before providing support and respected their decisions. This included not providing aspects of their support package if people did not want it. One staff member said, "I cannot force anyone to accept help but I will try to encourage."

Good

Is the service caring?

Our findings

People were complimentary about their regular care workers. Comments we received included; "[The care workers are] very polite, can't knock them", "They are always polite and with a jolly face and a smile on their face. And they just get on with the job", "They are absolutely amazing, I can't praise the carers enough", "Most of them are everything we would want in a carer - very kind, very nice and full of life" and "They are really very good and kind and often go the extra mile".

People said they enjoyed the time they spent with their care worker and relatives we spoke with confirmed that staff had built caring relationships with people. Comments we received included; "One of them puts her mobile phone on to music while Mum is having a wash and they do a sort of dance to it, she makes Mum really laugh" and "They are lovely and chat to my wife while carrying out the care".

However, people did say that sometimes they did not get their regular care worker and when their regular care worker was not available they were not always informed as to who was covering. One person said, "I never know who is coming through the door." Whereas another person said, "Yes we are always notified if it is someone different."

The care coordinators were responsible for allocated care workers to support people. They said they took into account the person's needs and matched this to staff's training and experience, as well as looking at gender and other individual preferences. The care coordinators told us they rang people early into the delivery of the care package to ensure they were happy with the care workers providing them with support.

Staff respected people's privacy, dignity and independence. One staff member said, "All the time communicate, shut the door so they feel safe and private, just keep talking and be respectful, communicate." Another staff member told us, "I always close the door of the room, let them (the clients) have choice let them do what they can do, only help with what they can't do - promote independence." A third staff member said, "We try our best to meet people's needs and we maintain their care as well as respecting their confidentiality and protecting their identity". People confirmed that staff were respectful, polite and gentle when supporting them.

People confirmed staff were considerate when supporting them and allowed them time to do as much as they could for themselves and involve them in day to day decisions. One staff member told us, "Of course they say how they want to be cared for and that's what I do" and "Show them the clothes; let them choose what they want. Encourage them to accept help, keep talking and encourage." We saw that people had specific goals set about what they wanted to achieve in order to maintain their independence.

People's care plans and initial assessment outlined their choices and preferences. This included in relation to how their care was delivered as well as in regards to religious and cultural preferences. Care records also detailed specific details such as any sensory impairment that needed to be taken account of when supporting people to make a decision. For example, ensuring they spoke loudly and clearly for people with hearing difficulties or that people communicated using basic sign language or by writing their decisions

down. Information was also collated about people's likes, dislikes, hobbies and interests. This gave staff information about how people liked care to be provided but also gave them information about what was important to the person, what they had experienced during their lives and what they enjoyed to help aid interactions and discussion.

Requires Improvement

Is the service responsive?

Our findings

On the whole people received person-centred care, however, this was affected by care workers not always arriving at the allocated time of call and there were instances where people needing support from two care workers only having one care worker arrive. One person told us, "They keep sending one carer who has to do a job of two. I am disabled and I need two cares not one." Some people described the service as "unreliable" and "sometimes even the best of them misses things out like this week one didn't empty my commode." Staff told us the scheduling of appointments and the lateness of rotas being sent out impacted on their ability to attend to all appointments and stay the required length of time as they were rushing to travel between appointments. People and care workers informed us often there were varying levels of communication from the care coordinators if a care worker was running late. Care workers told us they would inform the care coordinators if they were delayed but at times this message was not passed onto the person.

Despite these comments we heard from the majority of people that when their care workers turned up they provided person-centred care which met their needs. A relative told us, "Mum has four visits a day, she is completely bedbound and they are brilliant."

Staff told us they tried to meet people's preferences for timing of their care visits. However this was not always possible. They prioritised people that needed time specific calls due to their clinical needs, including if there needed to take medicines at a particular time or if they needed regular meals because of their diabetes.

An initial assessment was undertaken by the SQAs in discussion with people and liaison with the local authority placement team. From these assessments detailed care and support plans were written. People signed the plans to show that they had been involved in their development and agreed with them. People's care needs were reviewed at regular intervals to ensure the care being delivered still met people's needs. If staff identified that people's needs had changed this was discussed with the local authority funding their care and the care package was adjusted accordingly. Support plans were goal orientated and outcome focused. This included supporting people to "regain their previous level of functionality" and to regain their mobility and independence. We saw in one person's care plan they had stated "Everything has gone well all goals have been met".

Medacs healthcare delivered care packages in one London Borough to support people with end of life care. A dedicated staff team worked on this package. These staff had received additional training on end of life care to ensure they had the knowledge and skills to meet people's needs. Staff worked in close liaison with the local hospice to obtain further specialist advice and staff told us they could call the hospice staff if they needed any advice or support. If a person's health deteriorated staff had arrangements with the hospice to deliver the additional care, so that people did not need to go to hospital if this was their preference. People's choices and wishes regarding their end of life care were clearly documented in their care records.

People and/or their relatives were aware of how to make a complaint, however, they felt at times their

concerns and complaints were not listened to or adequately acted upon. One person said, "It is better for about a week and then goes back to what it was." We also heard from care workers that they felt when they raised concerns that these were not listened to and taken seriously. We also received comments that the complaint process had improved and staff were being more responsive to any concerns raised.

From analysis of the complaints received the management team were aware that the complaints themed around communication and time keeping. The management team had implemented new systems to help resolve some of these issues, including new scheduling systems and they told us complaints regarding care worker lateness were starting to reduce. We saw processes were in place to record all complaints received and these were monitored by the provider's central audit team to ensure appropriate action was taken to manage and respond to the complaint. From the completed PIR we saw the majority of complaints were responded to within the provider's agreed timescale and in line with their complaints policy.

The service also received a number of compliments and from their records we saw compliments included, "[The care worker] is an angel. He's kind, caring and very observant and does his very best to make [their family member] happy and comfortable" and "[The care worker] is a very good worker. Kind and supportive. [The care worker] does their work with a good heart".

Requires Improvement

Is the service well-led?

Our findings

We received mixed feedback about the management of the service. Comments included, "They have changed their attitude and tightened things up a bit…it is much better" and "The management is completely incompetent".

The management team had recently been restructured to provide clearer leadership and to account for the planned expansion due to the service successfully securing contracts with two additional local authorities. The regional operations manager was previously managing this service as well as undertaking their regional duties. The service had successfully recruited a branch manager during 2017 and they had a supportive handover before becoming the registered manager in January 2018. The staff team and care workers were structured around the different local authority contracts so there were dedicated teams to manage, monitor and deliver care.

There was an open and transparent approach to the management of the service. The management team described their style as "firm but fair". They said there was an open door policy and office staff confirmed the management team were accessible and approachable, however, we did hear that some care workers found it difficult to access the management team and felt communication could be improved. There were regular 'patch' meetings between care coordinators and care workers. These were held in the borough staff worked in to reduce travel time and improve accessibility. The 'patch' meetings gave staff the opportunity to discuss issues particularly to their geographical area and type of contract as well as discussing time keeping, team working, complaints and safeguarding processes.

There were processes in place to identify and address any staff performance concerns, with support from the provider's HR manager. The management team confirmed that when required they followed staff disciplinary procedures, including referring staff to professional regulators and the independent safeguarding authority. There were also processes in place to identify and reward exceptional staff practice. This included the use of Thank you cards, care worker of the month award and one-off rewards recognising individual staff.

There were systems in place to review the quality of service delivery. There was a programme of regular visits from the SQAs to observe the quality of care delivery as well as telephone monitoring calls to people completed by the care co-ordinators. There was a scheduled programme as to when these processes should be completed. We viewed the spreadsheets recorded the frequency of visits and saw this was in line with what was planned. We also heard from the management team that action had been taken to address specific concerns identified. There were also systems in place for the provider's central 'events' team to monitor key service data, including complaints, incidents, missed visits and safeguarding concerns.

The service had upgraded their electronic rostering system to address the ongoing concerns identified with scheduling, late and missed calls. The new system had it built it so there could be no clashes of calls and had a minimum travel time allocated to each call. The provider had also employed an administrator to monitor the CM2000 system care workers used to log the time of their calls to ensure this was in line with

people's support plans and to chase any late calls. The provider had also recently introduced new mobile phones for care workers with longer battery life. These phones had care workers' rotas on them and could be used for the care worker to log in and out at calls so this information was available to care workers and they could accurately record when they attended people's homes.

The provider had also changed their out of hours arrangements due to concerns identified with the previous system. The provider had bought the out of hours service in-house and was now based in the Croydon office with staff who were familiar with the geography and travel arrangements. Care co-ordinators were also available on call out of hours if specific support was required in regards to an individual care package.

These systems were relatively new at the time of our inspection and therefore we were unable to assess the impact of these changes on the quality of care delivery, and in regards to the challenges we found in regards to staffing. We will monitor the impact of these changes at our next inspection of the service.

On a weekly basis the SQAs reviewed the quality of care records kept at people's homes. Through this process they had identified there were current concerns regarding the completeness of medicine administration records. The SQAs were undertaking additional observation of the care workers where there were concerns about the quality of their records to review their competency and care workers were also asked to attend refresher training.

The management team welcomed feedback from staff, people and relatives. The provider organised an annual satisfaction survey to be sent to obtain feedback. This was due to be completed. From the previous year's survey we saw that people were generally happy with the quality of care they received, but that there needed to be improvements in regards to the communication from the office staff. In response to the survey care workers had been provided with feedback through a 'what you said, what we did' process. They were also issued with clear guidance that late and/or missed calls would not be tolerated. In addition to the annual survey, the Croydon branch had asked people for their views on three key questions to ensure they were happy with the service, they felt safe and they felt they received care from trained staff. This was completed in October 2017 and again in January 2018. We saw that between the two surveys there had been an improvement in the responses and more people felt happy and safe.

There was a daily phone call between all the branch managers in the region to discuss service delivery and share any learning or improvements. This was an opportunity to learn from each other and work together to improve the quality of care.

The management team had regular network meetings with each local authority they worked with. They told us the local authorities each set their own key performance indicators the service needed to adhere to for each contract and there were regular meetings and visits to discuss compliance with these targets. Relationships with representatives from the local authority and community professionals varied depending on the type of care package delivered. For the reablement and end of life support there was regular contact with community professionals, including from the local hospice.

The provider adhered to their CQC registration requirements, this included the submission of statutory notifications about key events that occurred. There had also adhered to the requirement to display their previous CQC rating at their office and on their website.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of staff deployed to meet people's needs and staff had not received sufficient training to ensure they had the knowledge and skills to undertake their duties. Regulation 18 (1) (2) (a)