Carewatch Care Services Limited

Carewatch (Brighton)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 5 December 2017 and was announced. This was the second inspection since a change in the legal entity of the service.

This service 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, and younger disabled adults mainly in the Brighton and Hove area but also in West Sussex. Care was provided predominantly to older people, including people with a physical disability, learning disability, sensory loss, mental health problems or people living with dementia. There were around 217 people receiving a service.
At the last inspection on 12 December 2016 the service was rated as requires improvement overall. The formal systems of quality assurance to monitor the standard of the service provided had not been fully maintained and embedded in the service. Regular reviews of people's care and support plans had not been fully maintained, care staff had not always had a regular appraisal and supervision or had spot checks carried out, and some refresher training was late in being provided to ensure the quality of the care provided to meet the provider's policies and procedures. At this inspection we found staff training, supervision and appraisal had improved, but reviews of people's care and support plans still had not been fully completed to meet the provider's timescale to undertake reviews.

On the day of our inspection, there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and staff told us it had been a difficult period with a number of staff changes. There had been a number of changes in care staff and vacancies had resulted in senior staff covering care calls at times. There had been a number of changes to the senior staff and office staff, and there were also a number of vacancies for senior staff which had affected the smooth running of the service. The registered manager told us there was ongoing recruitment to try to address this. This had not always ensured people's choices had been considered and person centred care had been provided.

People told us they felt safe with the care provided in their home. People's comments included, "They make sure they turn everything off, leave it tidy so I don't trip over anything," "I am absolutely safe with the carers, they are very efficient and kindly. It is always a pleasure to see them," and "I am very safe, they buzz and I let them in." However, people and their relatives told us they did not feel safe with the timing of the care calls, and not knowing who would be providing their care. People told us they did not always have their individual needs met in a timely manner and staff were regularly late for calls or people had experienced missed calls. One person told us care staff, "Come in at all times. Used to have a sheet with names of carers and times on don't get them now. Never know when they are coming in. Sometimes 8.30 am, now 10.30 am not arrived yet." Another person told us, "I do not know who is coming or at what time, it can be frustrating, weekends are chaos." A third person said, "Good safe care because I see the same people. Not so sure when new carers

come in. Don't know who they are and don't get lists, don't introduce themselves."

There were clear policies in place to protect people from abuse, and staff had a clear understanding of what to do if safeguarding concerns were identified. When new care staff were employed safe recruitment practices were in place to be followed. Assessments of risks to people had been developed. However, not all had been regularly reviewed. Staff told us they had received supervision, and been supported to develop their skills and knowledge by receiving training which helped them to carry out their roles and responsibilities effectively. People knew how to raise concerns or complaints.

The needs and choices of people had been clearly documented in their care plans. Care staff were able to tell us about the people they supported, for example their likes and dislikes and their interests. However, not all the care plans had been regularly reviewed to ensure any changes in people's care and support needs had been identified. People's comments included, "They did my care plan ages ago but no one comes to check if it everything is alright," and "Do phone sometimes to ask if everything is alright." People told us they were involved in the planning and any review of their care. Where people were unable to do this, the manager told us they would liaise with health and social care professionals to consider the person's capacity under the Mental Capacity Act 2005. Care staff had an understanding of the need for people to consent to their care and treatment.

The provider continued to have arrangements in place for the safe administration of medicines. People were supported to get their medicine safely when they needed it. If needed, people were supported with their food and drink and this was monitored regularly. People's comments included, "Food cooked well. I put meals in the freezer all labelled," "Sort and microwave all my meals. Really good support with meals," and "Will make sandwiches and leave them for my supper." People continued to be supported to maintain good health.

People and their relatives told us they were supported by kind and caring staff. One person told us, "Do what I want, very nice people, and no complaints." Another person told us, "Can't praise my carer enough. Very kind and thoughtful." A third person said, "Most of the carers are brilliant. Good relationship with four or five of them. If it wasn't for them I would have left the company. Do their job well."

Senior staff carried out a range of internal audits, and records confirmed this. These had identified areas in need of improvement, which staff were working to address.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. 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

The service was not consistently safe.

People had individual assessments of potential risks to their health and welfare. However, not all these had not been regularly reviewed. People did not routinely have their individual needs met in a timely manner.

People were cared for by staff who had been recruited through safe procedures. They had received safeguarding training and were clear about their role and responsibilities and how to identify, prevent and report abuse.

Procedures were in place to ensure the safe administration of medicines.

Is the service effective?

Good

The service was effective.

Care staff had an understanding around obtaining consent from people, and had attended training around the Mental Capacity Act 2005 (MCA).

There was a comprehensive training plan in place. Staff had the skills and knowledge to meet people's needs.

Staff had a good understanding of people's care and support needs. Where required, staff supported people to eat and drink and maintain a healthy diet.

Is the service caring?

Good

The service was caring.

Care staff involved and treated people with compassion, kindness, and respect.

People and their relatives were pleased with the care and support they had received. They felt their individual needs were

met and understood by staff.

People and their relatives told us care staff provided care that ensured their privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans were in place to ensure people received care which was personalised to meet their needs, wishes and aspirations. However, these had not been consistently reviewed. However, the scheduling of care calls did not always demonstrate people's choices had been considered and person centred care provided.

People had been assessed and their care and support needs identified.

People had received information on how to make a complaint if they were unhappy with the service provided. .

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People told us senior staff and office staff vacancies had affected the smooth running of the service..

Systems were in place to audit and quality assure the care provided. However, these had not all been fully maintained, and embedded in practice to meet the provider's policies and procedures.

Carewatch (Brighton)

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 checked 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 December 2017 and was announced. We told the registered manager 48 hours before our inspection that we would be coming. This was because we wanted to make sure that the registered manager and other appropriate staff were available to speak with us on the day of our inspection. An inspector and an assistant inspector undertook the inspection, with 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. The experts-by-experience made telephone calls to get feedback from people being supported.

At the last inspection on 12 December 2016 the service was rated as requires improvement overall.

The provider was not requested on this occasion to complete 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 looked at other information we held about the service. This included previous inspection reports and notifications. Notifications are changes, events or incidents that the service must inform us about. We spoke with the local authority commissioning team, who has responsibility for monitoring the quality and safety of the services they fund for people. We spoke with 26 people using the service and two relatives by telephone. We contacted five health and social care professionals for their experiences of the service provided and received one response.

During the inspection we went to the service's office and spoke with the registered manager, the manager who had applied to be the new registered manager of the service, head of quality, a quality officer, five care staff, a coordinator and a regional trainer. We spent time reviewing the records of the service, including policies and procedures, ten people's care and support plans, records of care provided and medicines administration records (MAR), the recruitment records for six new care staff, complaints recording, accident/incident and safeguarding recording, and staff rotas. We also looked at the provider's quality

assurance audits.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe with the care provided by their regular care staff in their home. People's comments included, "Very good always lock the door behind them," "Feel safe with my carer, a very nice person, and looks after me well," "I am very safe, they buzz and I let them in. But do not know who is coming, it is chaotic although I do know them and they are superb, it is a great comfort to have them around, they will do anything I ask that I cannot do for myself," and "Know I can trust them to do a good job. Never felt unsafe with them." However, people and their relatives told us they did not feel safe by not knowing the time their care calls were due to be made, and or not knowing who would be providing their care. One person told us they received, "Care three times a day. Don't always arrive so have to phone. Not always on time, and no rotas this week again so don't know who will be coming." Another person told us, "Difficult to say if they arrive on time because don't get a roster. Don't know who is coming in and what time. I have had to rely on my 72 year old neighbour to get me up sometimes." A relative told us, "Carers do turn up on time. Time sheets this week, all slots allocated not known that. Usually the slots are unallocated can be very stressful for mum, as she likes to know who is coming." Another relative told us, "Safe in terms of her core carer and good quality of care. Not safe in terms of the system. When they haven't turned up don't have a good system to let me or mum know. Mum is just left wondering if anyone is coming, not that safe." Where people relied on assistance at specific times due to their care needs the current system of scheduling care calls placed them at risk of not always get the assistance they needed when they needed it.

People provided a mixed response regarding the times care calls were provided. One person told us, "Most of the time, ninety-five percent turn up on time, somebody always comes along and never been left without care. I got a list of carers this week, but not as regular as it used to be. This week all named (Care staff) most unusual." However, the majority of people told us they did not know in advance what time the care staff would be arriving as they did not always receive a roster. When they did, this was not always adhered to and some people spoke of calls being missed. Where people told us they had contacted staff to ask for a roster, although it had been promised they had not received one. One person told us. "It is a waste of time ringing even if you get through, they do not ring you back when they say they will." Another person told us, "When a carer has not arrived I have phoned up to ask what has happened. They (Office staff) said, 'Can't always manage to get someone to you.' A third person said care staff, "Come in once in the morning anytime from 10.30 am to 1.0 pm. Been quite a few times when they haven't turned up, so I have had to get myself ready as best I can. Thursday I had a hospital appointment, no one came so missed it." Another person told us, they had expected a member of care staff at 9.0 am. They first called the office at 9.30 am when the care staff did not arrive, and was told someone would be coming. They had made two more calls and were still in bed at 11.30am when a member of staff arrived and helped support them to get up and with their personal care. The person had not had a hot drink or breakfast. Another person who required support to shower told us they did not have member of staff arrive until 12.0 pm despite several phone calls to the office. By this time they said they had struggled to get themselves washed and dressed, missing out on their daily shower. Where people relied on assistance at specific times due to their care needs the current system of scheduling care calls placed them at risk of not always getting the assistance they needed when they needed it.

We discussed this with the registered manager who acknowledged there were a number of staff vacancies

which were being covered by existing care staff, and senior staff. It had been particularly difficult to recruit care staff to work especially at the weekends which had led to a lack of consistency of care staff covering people's care calls. However, recruitment of new staff was ongoing to try and address this. When asked what could be improved in the service care staff told us, more staff and longer time between calls to enable care staff to travel to each location. We discussed the scheduling with senior staff who told us where possible care staff worked in a geographical area to allow for short travel times between care calls, which decreased the risk of care staff not being able to make the agreed appointment times.

People did not always receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. The scheduling of care calls placed people at risk of receiving late calls, or having their calls missed altogether. This was a breach of Regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Detailed assessments were undertaken to assess any risks to the person using the service and to the staff supporting them. Where possible people and their relatives had been part of the assessment process. However, not all had been regularly reviewed. Each person's care and support plan had an assessment of the environmental risks and any risks due to the health and support needs of the person, and these had been discussed with them. The assessments detailed what the activity was and the associated risk, and guidance for staff to take to minimise the risk. Care staff were able to confirm with us they had received training, had detailed guidance in place, and understood the procedures they were to follow. They told us the correct equipment such as a hoist had to be in place. Equipment maintenance was recorded, and care staff were aware they should report to senior staff any concerns about the equipment they used. However, feedback from people and staff was that risk assessments not had always been reviewed as a minimum to meet the timescale set by the provider to be completed. For one person we found their moving and handling risk assessment had not been reviewed to meet the timescales so it had not been ensured the person's current care needs had been identified and met. We discussed this with the registered manager who with senior staff told us they were in the process of reviewing the risk assessments. This is an area in need of improvement.

Comprehensive recruitment practices were followed for the employment of new care staff. The registered manager had the support of the provider's regional recruitment team when recruiting staff. They told us that all new staff had been through a robust recruitment procedure to meet the requirements of the provider's policies and procedures. We looked at the recruitment records for six care staff recruited, and we checked these held the required documentation. We found people had been through an interview, written references had been sought, and criminal records check had been carried out by the provider to ensure that potential new care staff had no record of offences that could affect their suitability to work with adults at risk.

Procedures were in place for staff to respond to emergencies. Care staff had guidance to follow in their handbooks and they were aware of the procedures to follow. There was guidance in place where care staff were lone working. There was an on call service available so that care staff had access to information and guidance at all times when they were working. Care staff were aware of how to access this. Any incidents and accidents were recorded and the registered manager told us she kept an overview of these. The provider was also informed so they could monitor any patterns and to provide guidance and support where needed.

The provider had a number of policies and procedures to ensure care staff had guidance about how to respect people's rights and keep them safe from harm. These had been reviewed to ensure current guidance and advice had been considered. This included clear systems on protecting people from abuse. The registered manager told us they were aware of and followed the local multi-agency policies and procedures for the safeguarding of adults. They had notified the Commission when safeguarding issues had arisen at

the service in line with registration requirements. Care staff told us they were aware of these policies and procedures and knew where they could read the safeguarding procedures. We talked with care staff about how they would raise concerns of any risks to people and poor practice in the service. Procedures were also in place to protect people from financial abuse. Staff described different types of abuse and what action they would take if they suspected abuse had taken place. Where care staff shopped for people if required, people told us on return from doing the shopping, care staff gave them a receipt which they both signed to agree the transaction.

There was a whistle blowing policy in place. Whistle blowing is where a member of staff can report concerns to a senior manager in the organisation, or directly to external organisations. The care staff had a clear understanding of their responsibility around reporting poor practice, for example, where abuse was suspected.

The majority of people told us they were able to take medicines independently. Some people who needed help removing pills from blister packs or applying skin creams, told us they had received good support. We did not receive any concerns from people in relation to medicines administration, or that the concerns raised in relation to the timing of care calls had effected medicines administration. People's comments included, "I do my own medication but sometimes they help me to get my tablets out of the blister packs and then I take them myself," "Put my cream on my legs every day and do it well," "Put my pills in my hand and I take them," and "Need reminding about my tablets. They never forget to prompt me." Care staff had received regular training in medicines administration. Regular auditing of medicine procedures had been maintained, including checks on accurately recording administered medicines. Where any issues had been highlighted about the recording this had been raised with care staff to rectify. This ensured the system for medicine administration worked effectively and any issues could be identified and addressed.

People were protected by the prevention of infection control. Staff had good knowledge in this area and attended regular training. PPE (Personal protective equipment) was used when required including aprons and gloves. The provider had detailed policies and procedures in infection control and staff received copies of these in their staff handbooks on induction.

Good

Is the service effective?

Our findings

People told us they felt staff were well-trained and competent, and provided a good level of care. One person told us, "Think that they are trained, and do a good job, know what they are doing when they sort my creams out." Another person told us, "Carers very fair, treated fairly. Never had a problem with anyone telling me not to do something." A third person said, "All very nice, know that I can't do some things, never moan, just do what I ask."

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 least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Staff told us they had completed training in the MCA. Staff we spoke with had a good understanding of consent, and where people lacked the capacity to make decisions about their care and welfare of the need to review this in the persons 'Best interest.' People told us care staff asked their consent before providing any care for example, by asking, 'Would you like me to, shall I, is it alright if I and what can I do for you today?' One person told us, "They always ask me before any care." One person told us they were "Treated with respect. Ask for permission before they put cream on my back and legs."

Staff had a good understanding of equality and diversity. This was reinforced through training and the registered manager ensuring that policies and procedures were read and understood. The Equality Act covers the same groups that were protected by existing equality legislation - age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership (in employment only) and pregnancy and maternity. These are now called `protected characteristics´. Staff we spoke with were knowledgeable of equality, diversity and human rights and told us people's rights would always be protected.

Senior staff told us care staff completed the provider's five day induction. This was confirmed in the training records we looked at. The induction incorporated the requirements of the Care Certificate. This is a set of standards for health and social care professionals, which gives everyone the confidence that workers have the same introductory skills, knowledge and behaviours to provide compassionate, safe and high quality care and support. There was a period of 'shadowing' a more experienced staff member, before new care staff started to undertake care calls on their own. The length of time new care staff shadowed was based on their previous experience, whether they felt they were ready, and a review of their performance. Feedback from care staff was that the induction had been good and informative. One member of staff told us, their induction was, "Amazing. (Trainer's name) helped us out a lot. I asked about Alzheimer's and dementia, and she gave me the interest (In these areas.) I contacted the local dementia team." They felt they were well prepared for their role. They confirmed they had undertaken initial essential training and completed a period of 'shadowing' an experienced colleague before working independently. One member of staff told us, "Practical training very helpful when new to the job."

Care staff received essential training and training updates that was specific to the needs of people using the service, which included training in moving and handling, medication, first aid, infection control, safeguarding, health and safety, food hygiene, equality and diversity and protected characteristics, infection control and dementia care. Care staff told us they were up-to-date with their training, they had received regular training updates and there was good access to training. However, training records for some care staff had just become overdue for their refresher training. This had been identified in the service's own quality assurance process as an area to be addressed. Senior staff told us this was in the process of being addressed and refresher training had been booked for care staff to complete. Care staff told us they had been able to complete National Vocational Qualifications (NVQ) or Qualifications Credit Framework (QCF) in health and social care. There was good communication between staff in the service who were informed when they needed to complete refresher training. They had received supervision and appraisal. Comments received from staff included, "Really supportive towards my needs," and "Feel like we get good support."

Staff undertook an initial assessment of people's care and support needs before they began using the service. This meant that they could be certain that their needs could be met. The assessment were used to develop a more detailed care plan for each person which detailed the person's needs, and included clear guidance for staff to help them understand how people liked and needed their care and support to be provided. Paperwork and feedback from people confirmed where possible they and their relatives were involved in the formation of an initial care plan and were subsequently asked if they would like to be involved in any care plan reviews.

Where required, care staff supported people to eat and drink to maintain a healthy diet. Care and support plans provided information about people's food and nutrition needs. For example for one person it detailed the need to ensure a drink in easy reach. For another person was detailed they liked help to prepare their breakfast in the morning and what they usually liked to eat and drink for breakfast. People were supported at mealtimes to access food and drink of their choice. People's comments included that care staff, "Make me a tea, get breakfast and get me ready to shower," "I get my meals delivered from (Company's name). Carers put them in the microwave," "Do get help with making my meals. Breakfast, lunch, supper. Use microwave but will do vegetables and cook them for me" and "Lunch in the microwave and get tea. Very helpful." A relative told us care staff, "Cook meals for mum and put them in the freezer. They microwave them for her and make her cups of tea. Will get her milk and bread in." If people had been identified as losing weight, care staff told us food and fluid charts were completed to monitor people's intake.

People had been supported to maintain good health and have ongoing healthcare support. We were told by people and their relatives that most of their health care appointments and health care needs were co-ordinated by themselves or their relatives. However, care staff were available to support people to access healthcare appointments if needed. Care staff told us they monitored people's health during their visits and recorded their observations. They liaised with health and social care professionals involved in their care if their health or support needs changed. People told us care staff were vigilant whilst doing personal care and should they have any concerns they had suggested referral to their GP. One person told us care staff had noticed a blister on the person's body during personal care. They arranged for a GP to call, this was now being treated with antibiotics. People's comments included, "I fell down on the floor and was on the floor for five hours. My carer found me and called the paramedics they wanted to take me to hospital but I said that I didn't want to go so they checked me over. The carer stayed until she was sure I was alright," "If I am not feeling well the carer will let the family know," "My carers are wonderful, one arrived to find me very unwell, they called an ambulance and went with me to hospital and stayed until I was settled, then returned to my flat locked up and made sure everything would be safe while I was away," and "If I asked I know they would ring the doctor for me. They told me that but not needed to." A relative told us the, "Carer will let me know if mum is not well."

Good

Is the service caring?

Our findings

People told us they were treated with kindness and compassion in their day-to-day care. They were satisfied with the care and support they received. They were happy and liked the staff. We were told of positive and on-going interaction between people and care staff. People's comments included, "My carers are really lovely, they look after me well. I respect this," "My carer is absolutely super, very good. Speaks nicely, has a sense of humour-we have a laugh," "Love the girls, have a laugh and a joke-good care," "I enjoy having them (care staff). We have a little natter whist they are showering me," and "My carers are superb, really lovely, I enjoy their visits; it is like having friends, they are so kind, show concern and will do anything for me, I value them greatly. They are so caring efficient competent compassionate and professional." When people were asked what they thought the service did well comments received included, "They are good at choosing staff," "Best thing, their lovely staff," "Best thing carers," "They have great carers, I get on well with them all," and "They will see to anything urgent if you are not well." One member of staff told us the, "Clients are great." Another member of staff told us, "I wanted to work with people different needs. I have had such a journey."

Staff had an understanding of the purpose of the service for example, the promotion and support to develop people's life skills, the importance of people's rights, respect, diversity and an understanding of the importance of respecting people's privacy and dignity. People told us they felt the care staff treated them with dignity and respect. People's comments included, "Am treated with respect, they listen to what I want especially when they shower me," "Always speak kindly to me and they make time to listen to what I say," "Very good when they shower me, towels to cover me," "I am not embarrassed when having personal care; the carers chat whilst doing it and we have a laugh and a joke which makes it more relaxed and easier." A relative told us, "Personal care is done well, respectful and gentle." Care staff had received training on privacy and dignity and had a good understanding of dignity and how this was embedded within their daily interactions with people.

People told us they had been involved in drawing up their care plan and with any reviews that had taken place. They felt that the care and support they received helped them retain their independence. Senior staff confirmed this and told us people were encouraged to influence their care and support plans. Care staff told us how they knew individual needs of the person they were supporting. They told us they looked at people's care and support plans and these contained detailed information about people's care and support needs, including their personal life histories.

For people who wished to have additional support whilst making decisions about their care, information on how to access an advocacy service was available in the information guide given to people who used the service. The registered manager was aware to tell people who they could contact if they needed this support.

Care records were stored securely. Information was kept confidentially and there were policies and procedures to protect people's personal information. There was a confidentiality policy which was accessible to all care staff and was also included in the care worker handbook. People received information

around confidentiality as well so they understood their rights. Care staff were aware of the importance of maintaining confidentiality and could give examples of how they did this.

Requires Improvement

Is the service responsive?

Our findings

People's regular care staff were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs, which enabled them to provide a personalised service. However, we found areas of practice in need of improvement in relation to reviews of care and support plans and with the scheduling of work to ensure peoples choices and wishes were taken into account.

At the last inspection on 12 December 2016 we found regular reviews of people's care and support plans had not been fully maintained. At this inspection we found this had not been fully addressed.

There was a formal process to review people's care and support plans. However, this had not been fully maintained to ensure people's care and support plans had been regularly reviewed to ensure their current care and support needs had been identified. Not all the care and support plans we looked at had been reviewed. Feedback from people was that not all had had a review of their care and support plan. Comments received when people were asked they had had a review of their care and support included, "They did my care plan ages ago but no one comes to check if it everything is alright," "Do phone sometimes to ask if everything is alright," "They did my care plan ages ago but no one comes to check if it everything is alright," "Care written in a folder, not had anyone talk about it but the carers are very good they record everything they do every time." "Not asked about my care plan. Not worried because nothing much has changed, get the care I need," "Don't bother to ring me to see if everything is alright," "Ring me up some times and do come to see me to talk about my care, " Haven't been asked (About care plan) No calls from the manager. A relative told us the, "Care plan was written over fifteen months ago with the social worker, the manager, mum and myself. Since then no invites to any further reviews. Care plan not brilliant now because the level of need has increased due to deteriorating health. Not enough time now so phoned the social worker and a review is supposed to being set up." Senior staff told us that formal reviews of the care and support plans had not been fully maintained. The recent changes in senior and office staff and staff vacancies had not helped. However, this had been identified and there was a robust action plan which the registered manager had monitored weekly to review progress to address this. The priority of the reviews was being completed using a risk based approach and where changes had been identified these were being completed first. The registered manager has subsequently told us two new senior staff had been recruited who would be working on the completion of the reviews. Staff told us where there had been changes to people. This is an area in need of improvement.

Before people started to use the service, an initial assessment took place. This identified the care and support people required to ensure their safety so staff could ensure that people's care needs could be met. Records we looked at confirmed this. People and their relatives confirmed an initial assessment had been completed and they had been part of the assessment process. This information was then used to inform people's care and support plan. One person told us, "I just said what I wanted and they put it in my care plan, I am happy with it, the carers follow it, they know my likes and dislikes and my funny little ways; it has been updated recently by a supervisor." Another person told us," My care plan is very flexible allowing for the unpredictability of my illness, carers take their cue from me, they listen to me and encourage me to do

whatever I can manage, although one carer will gently 'bully me' in a kind way into having a shower and hair-wash once a week."

Where specific staff preferences had been made, for example the use of male or female staff to provide personal care, this had been recorded and used to inform the scheduling process. However, the feedback was varied as to whether people were satisfied with the scheduling arrangements and the response they had received when raising this with office staff. People's comments included, "I don't like men to come and shower me. The service knows that and have agreed not on. Men have come and I am not happy. I have phoned but nothing done," and "When I first joined the service I said, don't like a man to shower me. They know but still sent a man. He was very nice but I don't like a man to shower me but not anything happened still sent him. Think they are short of staff," "I phoned because they sent a man out to shower me and I find it embarrassing. They said, 'You have to be showered by whoever comes.' Then they started arguing with me about the arrangement, not at all helpful. Don't quite know what's going on." People did not always feel their concerns had been adequately addressed. This did not always demonstrate people's choices had been considered and person centred care provided. This was discussed with the registered manager at the time of the inspection, who acknowledged this as an area of practice in need of improvement.

From 1 August 2016, all providers of NHS care and publicly-funded adult social care must follow the Accessible Information Standard (AIS) in line with the Equality Act 2010 and the Care Act 2014. Services must identify record, flag, share and meet people's information and communication needs. Although staff had not received AIS training they had ensured people's communication needs had been identified and met. The registered manager told us this was looked at as part of the comprehensive initial assessment completed. People's care plans contained details of the best way to communicate with them. For example asking the question, 'Do you have any difficulties in communicating your needs?' For one person their care plan detailed they wore a hearing aid in both ears, and they wold like care staff to ensure they were both in before leaving. Information for people and their relatives if required were created in a way to meet their needs in accessible formats to help them understand the care available to them. However, not all of the staff at the service were aware of the AIS and no policy, procedures or training around this had been implemented.

We recommend that the provider obtains information, sources training and implements policies and procedure in relation to compliance with the AIS to ensure this is consistently applied.

Technology was used with a system of telephone monitoring. This system required care staff to log in and out of their visits when they arrived and left. This system created information to reflect the time taken with each person and the time to travel in between visits. Carer staff logged in on arrival at the person's home. They scanned a bar code on the person's care plan with their work mobile phone. This also enabled care staff to access care plans and other information such as duty rotas.

We looked at how people's concerns and complaints were responded to, and asked people what they would do if they were unhappy with the service. People told us that if they were not happy about something they would feel comfortable raising the issue and knew who they could speak with. The complaints policy gave information to people on how to make a complaint, and how this would be responded to. The policy set out the timescales that the representatives of the service would respond in, as well as contact details for outside agencies that people could contact if they were unhappy with the response. The information provided to people encouraged them to raise any concerns that they may have. The provider had a system for receiving, recording and responding to complaints in a formal way.

No one at the time of the inspection required end of life care. The registered manager told us peoples' end

of life care would be discussed and planned and their wishes respected.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection on 12 December 2016 we found not all the quality assurance processes had been fully followed and maintained. Records we looked at identified some care staff were late in undertaking their refresher training to ensure they had the latest guidance to follow when providing people's care and support. Care staff had not had a regular appraisal and supervision and spot checks had not been consistently carried out to ensure the quality of the care provided.

At this inspection we formal systems of quality assurance to monitor the standard of the service provided were in place. For example, the medication administration records (MAR) and financial transaction records were checked for errors. Audits of care plans had been completed. Care staff had regular appraisal and supervision and spot checks had been consistently carried out to ensure the quality of the care provided. However, reviews of people's care and support plans were still in the process of being worked on. People had been asked to complete quality assurance questionnaires had enabled people to comment on the care provided. The feedback from this had been collated and used to inform the development of the service. These had identified areas in need of improvement, an action plan had been drawn up and which staff were working to address. However, the registered manager told us staff vacancies had delayed the regular review of care plans which had meant this was still in the process of being addressed. This is an area in need of improvement.

There was a clear management structure with identified leadership roles. The registered manager was also an area manager and was responsible for the overseeing of this and other of the provider's services. One senior member of staff told us, "(Registered manager's name) is very effective at getting things done. We have some wonderful carers and she is good at supporting and valuing carers." The registered manager told us it was the intention to have a dedicated registered manager for the service. A new manager had been in post since July 2017 and an application had already been made to the CQC for them to become the new registered manager for the service .The manager was supported by a team of quality assurance officers. Care staff told us,"Carewatch try to give best care," and "Communication levels are better, attitude towards carers has improved." The new manager was present for part of the inspection, but we have been informed they have subsequently left the service and that a further manager had been recruited and an application for a new registered manager made to the CQC. The registered manager was to be supported by four quality officers and only two who were new were in in post. The office was not fully staffed. There was not a full team of coordinators who undertook the scheduling. The one person in post was new and still learning their new role. The changes to senior and office staff and availability of care staff had not always ensured people were provided with person centred care and their choices had been met. This had affected the smooth running of the service. This is an area in need of improvement.

People told us of difficulties in communicating with office staff by not being able to contact office staff and they had not always been happy with the responses they had received. People's comments included, "Office management is in a bad state, we used to get a roster, I have asked for one three times this week, was told no; there was no 'sorry' and phone was put down on me," "Office are lax at times, they do not return calls or send rosters when they say they will," "I phone up two or three times a week to ask who is coming in. Calls

go unanswered and they have put the phone down on me. I know because I can hear the busy place in the background," and "They are short of staff, it is not the office staff's fault, they are doing their best." One person commented, "I find the office people a little dismissive because I am old. Don't like being spoken to as if I am a silly old woman." We discussed this with the registered manager whom acknowledged this had been a difficult time and recruitment was ongoing with a number of new staff due to commence working in the service to help address this. The staff vacancies had led to some tasks not being fully completed, for example, regular reviews of people's care and support plans. This is an area in need of improvement.

Policies and procedures were in place for staff to follow. Senior staff were able to show how they had sourced current information and good practice guidance, which had been used to inform the regular updates of the services policies and procedures. The provider had a clear set of values in place, which were understood and followed by staff. Staff demonstrated a clear understanding of these values.

The registered manager and staff worked closely with health professionals such as the local GP's and health specialists when required. Senior staff told us they worked very closely with all professionals they were in contact with, to ensure people received the correct care and treatment required. The registered manager was committed to keeping up to date with best practice and updates in health and social care. They were also aware of the CQC's revised Key Lines of Enquiries that were introduced from the 1st November 2017 and used to inform the inspection process. There was a policy and procedure on people's responsibility under the Duty of Candour. This is where providers are required to ensure the there is an open and honest culture within the service, with people and other 'relevant persons' (people acting lawfully on behalf of people) when things go wrong with care and treatment. The manager had regularly sent statistical information to the provider to keep them up-to-date with the service delivery. The provider also had internal systems of auditing the care provided. This enabled the provider to monitor or analyse information over time to determine trends, create learning and to make changes to the way the service was run.

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 People did not always receive the care and treatment required to meet their assessed needs, or which reflected their preferences or wishes. The scheduling of care calls placed people at risk of receiving late calls, or having their calls missed altogether.