Carewatch Care Services Limited

Carewatch (Ipswich)

Inspection report

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24 May 2018

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Ratings

Overall rating for this service	Inadequate

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

Summary of findings

Overall summary

This inspection took place on 17, 21 and 24 May 2018. The inspection at the office premises on 17 May 2018 was announced but the subsequent visits to people in their homes on 21 and 24 May were not announced to 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.

The previous registered manager of the service had left. The new manager had applied to register with the Care Quality Commission. 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 were not receiving care and support in a consistently safe manner. This was because risks to people from receiving care and support were not managed effectively. For example risk assessments were not in place for people who required the use of a hoist with moving and handling. This put people at risk of unsafe practise for example if the wrong size sling was used. Where the service was responsible for managing people's medicines this was not done in a safe manner. We saw examples of where medicines had been missed, or were stored inappropriately.

At the beginning of 2018 the service had missed a high number of visits. For the three weeks prior to our inspection there had been no missed visits. We discussed this with the manager and the provider's head of quality. They told us that measures had been put in place to recruit additional staff and schedule calls effectively so that visits were not missed. However, feedback we received showed that covering all of the calls was still proving challenging for the service.

People expressed dissatisfaction to us that the service did not always send out a rota detailing the person that would be visiting them to provide their care and support. They also told us that if they did receive a rota it was often incomplete and the times that staff actually arrived varied from that on the rota. People also expressed dissatisfaction that they were not told the time care staff would call with visits being scheduled as 'am' call, or tea call. Not receiving an accurate rota meant people felt unsafe and their lives were disrupted when they did not receive support at the appropriate time.

People did not feel encouraged or empowered to raise concerns with the service. Incidents were described to us by people which had caused them concern but they had not felt able to raise these with the service. Where people had made a formal complaint they did not feel that this had been dealt with to their satisfaction.

Staff training was not up to date and one member of staff told us they regularly provided care and support

having received no training from the service. This did not assure us that the service ensured staff had the skills and knowledge to deliver safe and effective care and support.

People were not always supported to maintain adequate nutrition. Where people required support with their nutrition effective care plans were not in place and food and fluid intake was not effectively recorded.

People were not supported to have maximum choice and control of their lives and were not supported in the least restrictive way possible. For example people had their medicines locked away in their homes without the appropriate procedures being followed. However, people told us that staff sought their consent before providing care and support.

We received mixed views as to whether care staff delivered care in a caring and supportive manner. Where people received support from a regular member of care staff they were complimentary but where a number of different care staff provided care and support, for example at weekends, the feedback was poor.

Care was not always delivered in the manner which the person requested and that care staff did not always stay for the required amount of time. We found that systems in place to check the duration of staff visits were ineffective. People also told us they were not able to choose the gender of the person providing their care and support.

The service had recognised that there were deficiencies in the care and support being provided when they took on staff and increased care hours from another provider. However, actions put in place to address the concerns had not resulted in an effective and timely improvement in care and support.

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. The service will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspected again within six months. The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate for any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

We were so concerned about the safety of people being supported by the service that after the inspection visits we contacted the provider. They have responded by putting measures in place which addressed our immediate concerns. You can see what action we told the provider to take at the back of the full version of the 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?

Inadequate

People were not safe.

Systems and processes in place did not encourage and empower people to raise concerns.

Risks were not identified and assessed with appropriate actions put in place to keep people safe.

Medicines were not managed safely and administered as prescribed.

Is the service effective?

Requires Improvement

The service was not always effective.

Not all staff had up to date training.

People were not always supported to eat and drink enough and maintain a balanced diet.

The service did not effectively implement the requirements of the Mental Capacity Act 2005.

People were supported with their day to day health needs.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People did not always feel that staff treated them with kindness and compassion.

Staff told us they did not always have time to provide care and support in a person centred way.

People's dignity was respected and they were supported to be as independent as possible.

Is the service responsive?

Requires Improvement

The service was not responsive.

People were not involved in developing their care plan.

People did not always receive care and support at a time which they required or preferred.

People did not always know how to complain. Where people did complain they did not feel it was dealt with to their satisfaction.

Is the service well-led?

Inadequate

The service was not well-led.

People told us that they did not think the service was well managed.

Prompt effective action had not been taken to address identified concerns.

Staff did not feel valued by the service.

Carewatch (Ipswich)

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 was a comprehensive inspection and took place on 17, 21 and 24 May 2018. The inspection was carried out by two adult social care 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 service. Our experts by experience had experience of receiving care and support at home.

We gave the service 48 hours' notice of the inspection visit because we needed to be sure that the manager would be available.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law. We reviewed the information the provider sent us in the Provider Information Return (PIR). This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

On the first day of the inspection we visited the agency office where we spoke with the manager and the providers head of quality. On the second day and third day of the inspection we visited three people in their home. We contacted 24 people and nine relatives of people who used the service and spoke with them on the telephone. We also spoke with two quality officers and six members of care staff.

We looked at three records which related to people's individual care needs. We viewed four staff recruitment files, training records, and records associated with the management of the service. This included policies and procedures, quality assurance processes, people and staff feedback, and the complaints process.

Inadequate

Is the service safe?

Our findings

Our inspection of September 2016 rated the service Good in the Safe key question. At this inspection we found that the service was Inadequate.

People told us that they felt safe when receiving care and support. One person said, "Yes, I feel very safe with them and they take me for a nice walk or round to the shops or the park." However we found that risks to people from receiving care and support were not managed appropriately and practices at the service placed people at risk of harm. For example some people using the service required the support of equipment such as a hoist or a stand aid when receiving care. Care plans we reviewed did not contain risk assessments relating to the moving and handling of the person and the use of the equipment. One person we visited in their home required the support of a hoist. The hoist used the type of sling which had different coloured loops to be used dependant on the size and weight of the person being hoisted. The care plan did not contain any information for care staff as to what loop should be used when hoisting the person. The person to be hoisted was unable to tell us which loop was used when they were hoisted. Using the wrong loop would put the person at significant risk of falling from the sling if it was set on too large a loop or receiving injury if the sling size was set too small.

Care plans in people's homes were not always accurate and up to date. When visiting one person in their home we attempted to open the locked box containing their medicines. The care plan described the medicines as being stored in a brief case with two combination locks. The medicines were actually stored in a plastic box with one combination lock. The number given in the care plan did not open the box. We contacted the service office and were given the correct number for the medicines. This inaccurate recording of the combination number could have put the person at risk if the emergency services had needed to access their medicines. Another person had been assessed as at risk of choking as they struggled to chew and swallow. An assessment by the speech and language team (SALT) had been carried out in February 2018. The information provided by the SALT team as the type and texture of food the person could eat had not been transferred to the care plan. This put the person at risk of choking if they were given food of an inappropriate texture.

Where the services was responsible for supporting people with their medicines people were put at risk because staff did not always administer medicines safely or as prescribed. Neither did the service always follow relevant guidelines around storing medicines, giving them to people, and disposing of them. For one person we visited, their medicine was stored in a locked safe in the kitchen. In the safe we found one tablet left in a box dated 13 March 2018. The medicine was an antibiotic. The person had been prescribed antibiotics for a urinary tract infection in March 2018. The medicine was not on the medication administration record (MAR). It appears that the person did not complete the course of antibiotics. Not completing a course of antibiotics put the person at risk of developing a resistance to the antibiotic. There was a blister pack dated 18 April 2018 left on top of the safe in the kitchen with two white tablets in one unopened section. A blister pack is made up by the chemist and has a sealed box for each day, with the tablets for that day in the box. The tablets left in the blister pack dated 18 April 2018 had not been given to the person as prescribed. The person's care plan referred to the use of analgesic gel. The person told us they

got severe back pain. There was no analgesic gel in the safe or recorded on the MAR. The carer visit sheet stated gel is kept in the safe but that the person self-administered. This person was not receiving adequate pain relief. For another person we visited their care plan stated that their medicines were dispensed from the original packaging. We found that the medicines in the person's home were in blister packs. However, there was a duplicate medicine to that in the blister packs in its original packaging stored with the blister packs. Care records contained no explanation as to why the method of administration had changed or why the medicine in its original packaging had been retained. This put the person at risk of receiving their medicine both from the blister pack and from that stored in the original packaging.

We also saw an example of where this person was not given their pain relieving medicine as the visit times had not left sufficient time between calls for the medicine to be given. The same problem had occurred two days later. This meant the person had not received their pain relief. The medicines error report had recorded that the co-ordinator was to ensure that a sufficient gap was left between visits. There was no record of whether this had been followed up to check that there had been no recurrence.

Across the service where people were receiving their medicine from a blister pack the service was recording 'As blister pack' on the MAR chart. The record of what was in the blister pack was not retained with the MAR chart. People's care plans did not always contain a record of what medicines they were taking and where there was a record these were not up to date. The medicines record in one person's care plan had last been updated in August 2017. This meant that no record was kept of what medicine that person had taken. This is contrary to national guidelines.

The service carried out audits of the completed MAR sheets. However, the audit did not include a check of the amount of medicines held against what the MAR sheet showed should be present. Staff we spoke with told us that there was no regular auditing in people's homes to check that the medicines held there agreed with the MAR sheet. This meant that we could not be sure that people were getting their medicine as prescribed.

All of the above represents a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

Information we hold about the service showed that there had been multiple missed calls by the service at the beginning of 2018. We asked the manager about these. They told us that things were improving and that there had been no missed calls or cancelled visits in the three weeks prior to our inspection. They went on to tell us that the service was undergoing a recruitment drive to improve staffing levels. The service is supported by a central recruitment team, based at their Head Office. They told us that the service was reviewing pay and conditions to support recruitment. Actions to reduce staff turnover were also being implemented.

People we spoke with confirmed that the number of missed calls had reduced however they still referred to staff being rushed and not arriving on time. For example one person said, "They do have a tight schedule and [carer] rushes to get away." Care coordinators who schedule carers to people's calls told us that they struggled to cover care visits and they did not have sufficient staff to cover all of the calls. This meant that if they did not have a carer to allocate to the call when compiling the rota the call was shown as 'unallocated'. They also told us that care staff had left due to the fact that they had been asked to work longer hours and go to different areas to cover all of the calls. They went on to tell us that they were currently trying to schedule four separate rounds of calls onto the computer. This would mean that people would receive more regular care staff and planning would be made easier. Another member of staff said, "Until we schedule runs we are fire fighting." However, at the time of our inspection only one of the four rounds had been scheduled.

The manager told us that they were working on scheduling the other three and would get this done as soon as possible. However, the lack of staff to schedule to the calls meant that some rotas were sent out to people with no named person for the call.

People told us that the rota system was not working. One relative explained to us they were not happy with the rota, "[Relative] needs to know who is coming to her home. It's about safety and well-being." They went on to tell us that a number of evening and weekend calls were unallocated on their relative's current rota. They then said, "I don't feel comfortable that strangers are going into [relatives] home at night and [relative] doesn't even have a name for them. It doesn't make it feel safe." Another person said they did not always get a rota and when they did, "There are so many unallocated slots I don't know why they bother with them."

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were not assured that people were encouraged and empowered to raise any concerns about their safety. One person told us, "One of them upset me when they said I'm not going to get better. One who helps me and I'm fed up with stuff like that." They then went on to describe an incident where they had not been treated appropriately. They had not felt able to report the incident to the service. They said, "I've not really complained formally. I don't like to." Another two people told us that they did not feel able to contact the service if they had any concerns with one describing a further incident which they had not brought to the attention of the service. Another relative gave us an example of how a member of care staff had exceeded professional boundaries with their relative but they had not brought this up with the office. Processes and practices did not protect people. People told us that they did not receive visits from staff from the service to discuss the care they were being provided with. Visits of this kind could support people to raise concerns.

Not all staff were up to date with safeguarding training. Not all care staff we spoke with displayed a good knowledge of safeguarding issues. Although most could tell us how they would escalate a concern. Poor knowledge and understanding by staff of safeguarding could result in care staff not recognising a safeguarding issue for people they were supporting. When a safeguarding issue had been reported by the service the organisation had policies and procedures to ensure they were investigated appropriately. The service utilises a centrally audited Governance Management System, which records all generated Safeguarding concerns, missed calls, and complaints. This system is maintained by the branch and monitored by senior management and remotely audited by the quality team to ensure compliance with published policies and procedures.

Appropriate arrangements were in place to ensure that the right staff were employed at the service. Relevant checks were carried out before a new member of staff started working at the service. These included obtaining a full employment history, gaining written references, ensuring that the applicant provided proof of their identity, undertaking a criminal record check with the Disclosure and Barring Service (DBS) and conducting pre-employment interviews.

People we spoke with gave a mixed response to staff hygiene practise. They told us that staff used personal protective equipment such as gloves and aprons and washed their hands. However, one person said, "They do me my meals, prepare them OK. [Carer] does good food but then she doesn't tidy the pots well. She just leaves them in cold water." Another person said, "One just does my lunch and a cup of tea, [carers] hygiene is not good. I've told them but it's not improved." Staff we spoke with had a good understanding of infection control.

The service told us in their Provider Information Return (PIR) that all complaints, missed visits and

safeguarding referrals were logged and analysed to enable us to trends to be identified regarding the volumes of complaints, safeguards and missed visits. They told us that the results of this analysis were incorporated into a branch improvement plan. As demonstrated above the service had responded to the number of missed visits by carrying out a recruitment campaign and also not taking on any new care packages in specific locations. However, the response had not been timely enough to prevent a high number of missed visits at the beginning of the year.

We were so concerned about the safety of people being supported by the service that after the inspection visits we contacted the provider. They have responded by putting measures in place which addressed our immediate concerns.

Requires Improvement

Is the service effective?

Our findings

Our inspection of September 2016 rated the service Good in the Effective key question. At this inspection we found that the service Required Improvement.

The service did not always deliver care and support in accordance with current legislation and evidence based guidance. For one person where advice had been given by the speech and language therapist (SALT) this had not been implemented into the care plan. For another person living with dementia there was no dementia care plan demonstrating how they were supported in line with best practice.

Where the service used technology to support the delivery of care services this was not always used effectively. For example, care staff were issued with smart phones, which they used to scan specially programmed tags located in the service users home care file. The manager told us that this allowed the service to monitor if the member of care staff stayed for the allocated time. An email was generated and sent to the office with this information. However, we identified that staff did not stay the allocated time from the written daily log. Staff responsible for checking the e mails told us that there were 40,000 on the system and they did not have time to check the e mails to ensure people were receiving their allocated care time. All care visits were being put onto the computer system to allow staff to effectively allocate calls to care staff. However, during our inspection this had not been implemented effectively.

Not all staff had received up to date training in safeguarding, manual handling or the administration of medicines. One member of staff who told us that they regularly went out to deliver care had received no training in these subjects since employed by the service. Staff told us that their training had been affected by the need to cover care calls. The documentation provided to us by the service which gave a percentage of staff training in each subject, and we understand was used by the management team to assess staffing needs also contained inaccuracies. For example one person whose training was recorded as up to date was recorded as Test Carewatch, another was recorded as Carer Office. The service also used a workbook entitled Safe to Practice which each member of staff should complete. It included information on the management of specific conditions such as diabetes, and Chronic Obstructive Pulmonary Disease [COPD]. Just over half of staff had completed the work book. This did not reassure us that the service ensured staff had the skills and knowledge to deliver effective care and support.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff told us that they received regular supervisions and that these were constructive and helped them to feel supported in their role. A supervision is where a member of care staff meets with a senior member of staff and discusses their performance and any concerns.

People were not always supported to eat and drink enough and maintain a balanced diet. For one person living with dementia there was no care plan in place for care staff to follow to ensure the person received adequate nutrition. Daily notes demonstrated that care staff had provided food for this person such as a

sandwich and a micro wave meal. However, the daily notes also recorded for another day that the micro wave had been moved by a member of care staff due to safety concerns. No action had been taken to ensure that the next member of care staff could prepare a meal. That member of care staff had written on the daily record, 'Left crisps and biscuits out as no way to cook a meal.' The service was recording the amount that the person ate and drank. However, the recording showed that for one day the person had eaten a bowl of cereal and two pieces of toast, for another day all that was recorded was a cup of coffee, a yoghurt and a glass of water. This did not demonstrate that the person's diet was being effectively monitored and that they were being supported to maintain a balanced diet.

This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that service policy was that before the service took on any new people to support a visit was made to the person to carry out an assessment of their needs and ensure the service could meet those needs. This was carried out to ensure that there was a smooth transition when a person moved from another service.

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 so that they can 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. We found that the service did not always carry out mental capacity assessments and, if the person was assessed and not having capacity, carry out best interest meetings to ensure that any actions taken were in the person's best interest and the least restrictive. For example we found two examples of where people had their medicines stored in a locked container. In neither case could we identify that the person had given consent for this or the reasons it had taken place. In one case we asked the person why their medicines were locked in the container and they replied, "I don't know ask him," indicating their relative. We asked the relative why the medicine was locked and they replied, "I don't know they [service] deal with all that." The care plan contained no record of why the medicines were locked away or any consultation with the person or their representative. In the other case the service had identified that the person needed their medicines to be given by staff but there was no record in the care plan as to why they were locked away or any consultation.

People told us that staff sought their consent before providing care and support. One person said, "They're good like that. They never just assume they can do something." A relative told us they had heard care staff talking with her [relative] and go through everything that is needed before they start. They check he's ready as well."

People told us they were supported with their day to day health needs. One person said they felt confident to speak about their health care needs with care staff saying, "They are good at listening." They also said, "I can't get out much because I'm very disabled, care staff will take a urine sample to the doctor for me and help generally like that." A relative said, "Carers generally come to see me. They say [relative] isn't feeling very well. They suggest I make an appointment with the doctor." Another relative said, "If [carer] sees anything they point it out and [carer] keeps an eye on it."

Requires Improvement

Is the service caring?

Our findings

Our inspection of September 2016 rated the service Good in the Caring key question. At this inspection we found that the service Required Improvement.

We received mixed views as to whether staff treated people with kindness, respect and compassion. Where people received support from regular members of care staff they told us they were treated well. However, when people did not have regular care staff providing their care and support this was not always the case. This was illustrated when one person told us, "I've had nothing to complain about, but when my usual carers are not here the agency staff are called in. They don't get it right. They are often spending time on the mobile and they miss out details so if it's not the Carewatch staff they are not as good." Another person told us that they had two carers that one was nice but one was rude, "Not threatening but tells me off and makes me feel bad." Another person said, "The regulars are very good they have a bit more life experience. The younger ones are not dedicated. They don't do a good job they rush it. Rush drying me."

We received the same response when we asked if staff knew the people they were supporting. People told us that if they received support from regular carer's people were satisfied but if they received a variety of care staff it was not good. For example one person said, "I have a different one [carer] each day. They are all good but they don't know me." A relative told us that their relative had some regular carers who were very good. They said, "They do things like make [relative] bed and a cup of tea. Others however, are okay but do not do the little extras. They don't seem to notice things like the bed and the laundry." We saw an example of care staff not recognising when a person may need a little extra support when we visited a person in their home. The person was living with dementia. The member of care staff had left the person with yoghurt for their lunch and this was recorded on the daily notes. However, they had not left the person with a spoon to eat it with.

From talking to staff we did not find that they understood and promoted compassionate, respectful and empathetic behaviour within the staff team. Difficulties with covering calls and differences in pay when Carewatch Ipswich took over another service had caused friction in the staff team. Some staff told us that they believed that pressure to work more hours than they wanted had caused a number of care staff to leave. One member of care staff told us that since the company had changed they no longer felt part of a team.

Staff told us that they did not always have the time required in the call to provide care and support in a compassionate and personal way. One said, "There is not enough time to provide the care when time is required to read the care plan and the service is only 15 minutes. 15 minutes is not viable." Another said, "The 15 minute service is very difficult to do all the tasks required. If the person needs the toilet, cleaning, changing, medication and writing in the book. It is not possible." Another member of care staff felt that because of time constraints they had to provide care in a task driven way and did not have time to talk to people as they would wish. They gave an example of having no time to talk to a person who was quite lonely and how they felt sad that they did not have time to for more social interaction with the person. However, people told us that care staff supported them in a caring manner, particularly by care staff who knew them.

One person said, "I like to be slow in the mornings. I need peace and slow. The regular carer does their best never hurries or makes much noise around me. Others carers who don't know me so well often move around fast and bang things." Following our inspection visits the provider told us that they regularly go back to the local authority commissioning team when the time given for calls was not sufficient.

People told us that staff respected their privacy and dignity while providing care and support. One person said, "It's the way they do it. The bathroom door is kept closed. I'm never concerned, never." Another person said, "Carers are wonderful. I have the shower curtains around me, a hand comes out and gives me the shower gel. They do the bits I can't reach."

Staff supported people to be as independent as possible. One person said, "I try to do as much as I can myself and the carer encourages me to do that. [Carer] lets me get on with it, steps in only if I get stuck." A relative said, "[Relative] can't walk too far anymore. They encourage [relative] to do what they can though. They let [relative] do what they can before they step in."

Requires Improvement

Is the service responsive?

Our findings

Our inspection of September 2016 rated the service Good in the Responsive key question. At this inspection we have rated the service Requires Improvement..

People were not involved in developing their care plan. One person told us they had not had any contact with the agency since the new provider had taken over and did not know when their care plan would be reviewed. Another person did not know how often their care plan should be reviewed and said no-one from the agency had come out to her or gone through her care with her.

Care plans we looked at did not demonstrate that they had been regularly reviewed to ensure that they met people's changing needs. We saw an example of where a person's mental state had changed and staff had brought this to the attention of the service in March 2018 but the care plan had not been updated to reflect these changes. The last face to face review with the person had been in February 2018.

People told us that Carewatch did not tell them what time their carer would call and were not able to provide support at the times they required or preferred. Records we checked showed that the service gave broad timescales for visits such as 'am call', lunch call, tea call and bed call. One person said, "[Relative] gets ready early at 6 or 7 or even 5 o'clock though it should be 6 or later, but sometimes it's all much earlier." Another person said, "They don't listen so no I don't have control. I asked them to send someone in the morning. I've just been told he's coming at 6.30 this evening." Records we checked showed that on two occasions one person had not received their medicine because insufficient time had been left between calls.

People told us that carers often ran late, which caused problems. A relative said, "[Relative] has activities at the Day Centre, and this helps [relative] keep up an active life and socialise, but they need to be here by 8.30am. Some people turn up finally at 9am which is too late. [Relative] really likes the activities[Relative] enjoys them and it helps improve [relative] quality of life." Another person gave us an example of where they needed to get to a hospital appointment and their carer had arrived an hour later than expected. They said, "It put me under huge pressure to get to my first appointment," and went on to say that the amount of time with the carer had had to be cut short. We were also given examples where staff called to get people ready for bed much earlier than they wished. One person said, "One they came at 6.15pm to put me to bed. I didn't want to go to bed at that time. "People also told us that because they could not rely on care staff arriving when expected they tried to do more for themselves than perhaps they were able.

The manager told us that the service sent out rota's so that people knew what time and who would be arriving to provide their care and support. However, people consistently told us that they did not receive a rota and if they did it was not correct or was not fully completed. A relative told us, "I think it's mostly the care is good, the people who call. What goes wrong is the scheduling. I'm not sure if we've got a rota. They've not sent one for a while now, they change it, it's not reliable about whom and when they are calling. Typically the slots are often unallocated."

People also told us that not receiving support from regular care staff could impact on their well-being, this

was particularly apparent from relative of people living with dementia. One relative said, "[Relative] needs a regular carer because of dementia. The impact of seeing so many difference faces is that it confuses [relative]." Another said, "[Relative] needs the same faces, [relative] has dementia as well now, needs people he can recognise and know."

We had concerns that due to the length of call times not always being adhered to people did not receive appropriate care and support. Whilst some staff stayed with people for the correct amount of time, we found some call times were not appropriate. For example, one person required a 30 minute lunchtime call for support with a meal and personal care. We saw instances where the call had only been 5 minutes long. Another person required 30 minute calls for support with personal care and continence but we saw they had regularly received 20 minute visits with some as short as 10 minutes. The manager told us that the electronic call monitoring system was regularly checked to ensure staff stayed the required time. Staff using the system told us that it did not work effectively.

Care plans did not demonstrate that people had been offered a choice of the gender of the person providing their care. One person said, "Recently they wanted me to take a male carer but I will not have one." Another person told us they had asked for a female to support them but a male member of care staff was still being sent. Another person who was being supported by a male carer said, "It's a gentleman, I don't really mind, though I wouldn't have chosen that." Where people had expressed a wish not to have a particular member of care staff supporting them this was not always accommodated. One person told us, "I told them I don't want [named carer] and they did not come out to see me. They just told me I have to have [named carer].

The above demonstrates a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that the service had a complaints policy and that formal complaints were recorded and the response monitored by the provider. However, people we spoke with were not always aware of how to make a complaint. One person told us that they had not been given any details of who to contact the agency otherwise they would have e mailed their current concerns around time keeping to the agency. They said, "If I had their e mail address I would have done it by now."

Where people had made a complaint they told us this had not always been dealt with to their satisfaction. Where one person had raised issues regarding time keeping they did not feel that the Carewatch response was useful or good enough. Another person said, "I complained strongly about three months ago. They told me a load of rubbish and I found that out when she [carer] arrived. They had told me a different story."

The above demonstrates a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Where people had been invited to express their views about their care and support by means of a questionnaire they did not feel that this had been useful or enable them to express their views. One person said, "I've had a questionnaire but it's not helpful because the questions don't fit with what I have." Another person told us they had had a questionnaire but did not feel the questions were helpful or relevant to their experiences so did not fill it in.

At the time of our inspection, we did not look at any care plans for people who were specifically receiving end of life care. However, in the care plans we did look at people's advanced wishes were not recorded

Inadequate

Is the service well-led?

Our findings

Our inspection of September 2016 rated the service Good in the Well-led key question. At this inspection we have rated the service Inadequate.

Some people expressed a low opinion of the management of the service. One person said, "They need to do better. They are not very organised." Another person was complimentary about the care staff but referring to the management said, "…but the management is poor at communication. They don't let me know if the carer is running late and there hasn't been any communication since they took over, not even who to contact. Another person had the same view saying, "Overall I think they need to organise themselves better, but the front line staff are very good."

The service had gone through a period of change since our last inspection taking on a large number of new care packages along with staff from another provider. The registered manager no longer worked at the service and a new manager had been recruited. The new manager had applied to the CQC to be registered.

Staff we spoke with had been unsettled by the changes and this was reflected when we spoke with them. Some who had worked for the previous service frequently referred back to that service. Staff told us that a discrepancy in pay between the two services had not been addressed. This had caused unrest in the staff team when staff on different rates of pay were required to work together. Another member of staff referred to a staff recognition scheme that had previously been in place but they understood was no longer in use. The provider has subsequently told us that they are operating the same recognition schemes. The member of staff was not aware of this. They told us that the effect of the changes had been that a large number of staff had left the organisation as they did not feel valued. The manager told us that they had recognised that the pay discrepancy had had an effect on their staff retention and had worked with the provider to address this. However, we noted that this had not been addressed before the number of staff leaving had had an impact on the quality of care provided.

In their Provider Information Return the provider detailed to us a raft of quality control measures to ensure the service was well-led and provided a good standard of care. These included a Quality Team, a Training Team, a Compliance Manager, Operations Support, a Finance Team, Contracts Team, Procurement Team, an IT Team, a Project support Team, a Human Resource Team and a Recruitment Team. It had been recognised that there were concerns with the quality of the service when the service took on the new staff and care packages. Actions to address these concerns agreed with the local authority had included not taking any new care packages in specified areas. They also told us that there was a Quality Improvement Plan in place which had been agreed with the local authority in January 2018 and that the Quality Improvement Plan was 'a live and dynamic working document which is shared and worked on regularly by all branch staff to continually improve our service'. However, at this inspection we identified there were still serious concerns with the quality and safety of the service provided which had not been fully addressed by the improvement plan almost six months later. The slow pace of improvement meant that people continued to receive poor quality care.

The new manager had put in place regular meetings with care staff, quality officers and care coordinators. Minutes from these meetings showed that staff had felt able to raise concerns. However, we did not see from the minutes that the opportunity to feedback to staff at subsequent meetings, any actions that had been taken as a result of their concerns had been taken. We also noted that there was a disconnect between what staff in the office were telling us and what care staff told us particularly in regard to availability of care staff. Care staff told us that they were not getting sufficient hours given to them. However, staff from the office who allocated the calls told us there were not always sufficient staff to cover the calls. The manager told us that this would be addressed by the scheduling of calls to specific care rounds and that this work was ongoing.

The above represents a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager was receiving support from the provider in their role. This included on the ground support from another manager who was working with them in the service and regular visits from staff from the providers head office. They were also undertaking management training.

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 9 HSCA RA Regulations 2014 Person-centred care People did not receive appropriate care and support which reflected their preferences.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Adequate risk assessments were not in place. Medicines were not managed safely

Regulated activity	Regulation
Personal care	Regulation 14 HSCA RA Regulations 2014 Meeting nutritional and hydration needs Where people required support with their nutrition care plans were not in place to support this.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Processes to ensure compliance with the regulations were not enacted in a timely way.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff employed to provide the care and support required.

Staff had not received up to date training.