Claire Meade Care Limited

Caremark (Bradford)

Inspection report

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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

About the service
Caremark (Bradford) is a domiciliary care agency which provides personal care to people in their own homes. At the time of the inspection the service was providing personal care to 159 people.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

People's experience of using this service:
People provided mixed feedback about the overall quality of the service they received. Most people were happy with Caremark however there was a sizeable minority that was unhappy and said management had not been effective in addressing their issues or concerns.

Medicines were not managed in a safe or proper way. People did not always receive their medicines as prescribed and medicines administration records were not always clear or fully completed. Unsafe medicines management had been an issue at the last three inspections demonstrating the service had a poor track record in this area.

Some risks to people's health and safety were assessed but this approach was inconsistent. We found a number of key risk assessments missing or lacking the required detailed.

Most people told us they felt safe using the service. However there had a been a high number of safeguarding incidents and we saw robust systems were not always operated to protect people from abuse or harm.

People said there were variations in the quality of staff and some unsuitable care workers that shouldn't be working for the service. We saw robust recruitment procedures were not always operated.

Staff received a range of training and support which was relevant to their roles. Training was kept up-to-date. However, some people experienced a high number of different care workers in a given week or month which was a barrier to providing consistent, high quality care.

Most people received calls at the times that they needed them, however this was not consistently the case. A number of calls were significantly shorter than they should have been, and some people said staff rushed.

Most people said staff were kind and caring and treated them well. However, this view was not universal, and a number of people gave us examples of how they had not always been treated with dignity and respect by staff or the management team.

People were not always supported to have maximum choice and control of their lives and staff did not support them in the least restrictive way possible and in their best interests; the systems in the service did not always support this practice.

The service was not well led because the service continued to be in breach of regulation and had not deteriorated since the last inspection. Audit and checking procedures were not suitably robust in identifying errors and taking action to prevent them re-occurring.

We found seven breaches of regulation. We raised these issues with the service and requested an immediate action plan to state how they would mitigate the risks to people. We also made safeguarding alerts to the local authority about some of the more serious concerns.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection and update
The last rating for this service was requires improvement (published 14 August 2019) and there were two breaches of regulation. We issued two warning notices, for regulation 12 safe care and treatment and for regulation 17 good governance.

At this inspection the service had not improved or met the warning notices and was still in breach of these regulations.

Why we inspected
The inspection was prompted in part due to concerns received about overall care quality and due to a number of safeguarding incidents which had occurred in the service. A decision was made to bring the planned comprehensive inspection of this service forward to allow us to inspect and examine those risks.

This inspection was also carried out to follow up on action we told the provider to take at the last inspection.

We have found evidence that the provider needs to make improvements. You can see what action we have asked the provider to take at the end of this full report.

You can read the report from our last comprehensive inspection, by selecting the 'all reports' link for Caremark (Bradford) on our website at www.cqc.org.uk.

Enforcement

We have identified breaches in relation to person-centred care, safe care and treatment (medicines and risk management), safeguarding, consent, recruitment, complaints and good governance.

Please see the action we have told the provider to take at the end of this report.

Information about CQC's regulatory response to the more serious concerns found during inspections is added to reports after any representations and appeals have been concluded.

Follow up

We will request updated action plans to understand what they will do to improve the standards of quality and safety. We will work with the local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

Special Measures

The overall rating for this service is 'Inadequate' and the service is therefore in 'special measures'. This means we will keep the service under review and, if we do not propose to cancel the provider's registration, we will re-inspect within 6 months to check for significant improvements.

If the provider has not made enough improvement within this timeframe and there is still a rating of inadequate for any key question or overall rating, we will take action in line with our enforcement procedures. This will mean we will begin the process of preventing the provider from operating this service.

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.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not safe.

Details are in our safe findings below.

Inadequate

Is the service effective?

The service was not always effective.

Details are in our effective findings below.

Requires Improvement

Is the service caring?

The service was not always caring.

Details are in our effective findings below.

Requires Improvement

Is the service responsive?

The service was not always responsive.

Details are in our effective findings below.

Requires Improvement

Is the service well-led?

The service was not well-led.

Details are in our safe findings below.

Inadequate

Caremark (Bradford)

Detailed findings

Background to this inspection

Inspection team
The inspection team consisted of three inspectors, an assistant inspector and an Expert 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.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided. A new managing director had also been appointed who was helping run the service on a daily basis and told us it was their intention to apply to become an additional registered manager for the service. We refer to them is this report as the managing director.

Notice of inspection
The first day of this inspection was unannounced.

Inspection activity started on 4 June 2019 and ended on 17 June 2019. On the 6 and 13 June we visited the provider's offices to review documentation relating to people's care and the management of the service. On the 16 June 2019 we visited people in their homes to ask them about their care and support, check how medicines were managed and review care related documentation. Between 4 and 17 June 2019 we made phone calls to people who used the service, their relatives and staff.

What we did before the inspection
We reviewed information we had received about the service since the last inspection. We sought feedback from the local authority and professionals who work with the service. We used the information the provider sent us in the provider information return. This is information providers are required to send us with key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections. We used all of this information to plan our inspection. We used all of this

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During the inspection
During the inspection we spoke with ten people who used the service and 17 relatives of people who used the service. We spoke to most people via the telephone but also undertook visits to five people's homes. We also spoke with 14 care workers, the registered manager, managing director and operations manager. We reviewed 13 people's care and medicines records. We also spoke with one professional who worked with the service.

After the inspection
We continued to seek clarification from the provider to validate evidence found and asked for an immediate action plan to mitigate some of the risks identified.

Inadequate

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now deteriorated to inadequate.

This meant people were not safe and were at risk of avoidable harm.

Using medicines safely
At our last three inspections the provider had failed to ensure medicines were managed in a safe and proper way. This was a breach of regulation 12 (safe care and treatment) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the service continued to be in breach of regulation as we found widespread concerns relating to medicine management.
• During visits to people's homes we found risks associated with medicines. For example we found an out of date inhaler in use, a prescribed medicine not being given by staff, and other medicines not being given safely as per agreed plans of care.
• Staff were crushing medicines into food for one person to aid swallowing. There was no care plan for staff to follow and the provider was not following the advice from a pharmacist on how medicines should be crushed and administered individually, which increased the risk the medicines would not work properly and there would be unintended side effects.
• Medicines administration records (MAR) were poorly completed with items crossed out, gaps and other inconsistencies. As such we were not able to reassure ourselves that people had received their prescribed medicines. For example, one person had an antibiotic prescribed to be taken four times a day for a seven day period from 7 May 2019. The MAR and daily notes indicated it was only administered twice on 7 May, four times on 8 May and once on 9 May.
• We found a complete record of the medicine support provided was not always present. Where staff signed to state they had given medicines from a dossette box a list of the medicines given was not always clearly attached.
• Medicine profiles and risk assessments did not contain sufficient details of the medicine management arrangements in place. In some cases, families were assisting with medicine support, but this arrangement was not clearly set out in care planning.

This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. Some people had experienced unsafe medicine management practices putting them at risk of harm. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with medicines management.

• Staff had received training in medicines management and had their competency to give medicines assessed.

Systems and processes to safeguard people from the risk of abuse
• Systems were not fully in place to fully protect people from abuse.
• Most people said they felt safe in the presence of staff. One person said, "I trust them and feel comfortable with them." However, a number of people complained that some staff were unsuitable, and some people said that items had gone missing from their houses.
• There had been a high number of safeguarding alerts about the service which were being investigated by the local authority safeguarding team. Whilst the new managing director demonstrated they were taking action to learn from incidents, some of these incidents had resulted in unacceptable care failings.
For example, staff had not taken appropriate action through care planning or delivery to act when a person was refusing support and another person had experienced a missed call due to multiple failings resulting in them remaining in their armchair all night.
• Some staff were not permitted to work with certain clients due to past incidents or allegations. However, there was a lack of information recorded as to why this was the case, leading us to conclude that these had not been fully investigated and/or followed up.
• Systems were not in place to protect people from financial abuse. For example, one person told us staff took money out of the cash machine for them and bought their shopping however this was not properly risk assessed and there was no record of the transactions undertaken by staff.
• There was a lack of robust system for ensuring financial records were subject to audit and checking procedures.

This demonstrated the service was not taking sufficient action to protect people from abuse. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people had experienced direct harm as a result of this breach. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with safeguarding.

• The new managing director on the instruction of Bradford Council had put in place a new system whereby they spoke with staff on a daily basis following their shifts, to help ensure that any concerns or risks identified during care visits were known to the management team. This was aimed at helping to improve oversight of risk.

Assessing risk, safety monitoring and management
• Risks to people's health and safety were not always fully assessed and mitigated.
• People provided mixed feedback about the safety of the service. A number of people raised concerns that staff did not always practice safe manual handling techniques. For example, one person told us care staff had caused pain and distress during transferring and another two people told us staff had hurt them whilst using the hoist. A relative also told us some staff did not know how to use the hoist correctly. When we looked in their relative's care plan it did not provide sufficient detail for staff on how to handle them safely.
• People had risk assessment and care plans in place. Some of these were detailed however others were very generic, did not assess the level of risk properly or provide clear instructions to staff on how to reduce the risk. For example, risks associated with nutrition, skin and moving and handling were not always sufficiently assessed and there was a lack of information and/or risk assessment about some of the equipment staff were expected to use such as bed rails and cough assist machines.
• We visited one person in their home and saw they were prescribed a nutritional thickener, however there were no instructions to staff on how much to use. Their care records also showed they should be provided with a pureed diet; however, staff were no longer providing this, going against the agreed plan of care. We raised this with the managing director who requested an urgent Speech and Language Therapy (SALT) assessment.

Because of the lack of robust risk assessments and some unsafe practices we witnessed or were told about we concluded the service was not providing safe care and treatment. This was a breach of regulation 12 of the Health and Social Care Act 2008 Regulated Activities 2014 Regulations. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with risk management, to protect people from harm.

Staffing and recruitment
• We found there were enough staff to ensure people received care and support. Most people said that they received calls at consistent times each day although not everyone thought this. One person said "reliable and on time. If there's a delay they let us know." Another person said "Sometimes we're happy and sometimes we're not. Calls are late or too early for example coming at 3pm for the teatime call which should be 4.10pm. We have done lots of complaining."
• We saw calls usually took place at the same time each day and there was generally an acceptable level of consistency in call times from day to day. Staff said rotas were manageable and they were usually able to get to calls on time.
• Recruitment procedures were not suitably robust to ensure that staff were consistently of good quality. Our review of records showed there had been a number of incidents which demonstrated staff were not consistently of the required standard to care for vulnerable people. A number of people told us that there were unsuitable staff working for the company, whom they had to 'ban' from visiting them or their relatives. One relative told us "they'll employ anyone."
• We reviewed recruitment records. One staff member had been recruited and their DBS (Disclosure and Baring Service) check had shown convictions. However, the risk assessment in place was not suitably robust and there was no evidence of discussing the DBS with the person. Another person had declared offences on the application form, but these had been followed up with the person at interview.
• In seven of the nine staff files we looked at gaps in a person's employment had not been suitably explored in line with legislation.

These shortfalls in recruitment procedures demonstrated the service was in breach of regulation.
This was a breach of regulation 19 of the Health and Social Care Act 2008 Regulated Activities 2014 Regulations. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with recruitment practices.

Infection Prevention
• People generally said staff adhered to good infection control principles. Staff received training in infection control and this was checked during spot checks of their practice.
• However, two people told us that staff left disposable gloves in the garden and did not put waste in the correct bins. One person's medicines had recently been stored in unhygienic conditions and a relative told us how care workers had not ensured the fridge was always left in a hygienic state.

Learning lessons when things go wrong
• The new managing director was taking action to investigate incidents and showed us evidence of a number of areas where they had learnt lessons from individual incidents to help improve the quality of the service.
• However, there was a lack of robust system to record and analyse incidents. Incidents, allegations and concerns were logged in a number of different places. The new managing director told us that incident forms were not being used effectively by staff. It was therefore difficult to analyse and review the number and type of different incidents that had occurred within the service.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At the last inspection this key question was rated as good. At this inspection this key question has now deteriorated to requires improvement.

This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Ensuring consent to care and treatment in line with law and guidance
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as 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. Where people may need to be deprived of their liberty in order to receive care and treatment in their own homes, the DoLS cannot be used. Instead, an application can be made to the Court of Protection who can authorise deprivations of liberty. We checked whether the service was working within the principles of the MCA.

- Where people had capacity to consent to their care arrangements we saw they had signed to agree to their plans of care. Where people lacked capacity, relatives had been involved in this process. However, we found the service was not always compliant with the requirements of the MCA.
- One person was receiving their medicines covertly however there was no best interest process followed to ensure their rights were upheld. Another person's medicines were locked away in a box to which they did not have the key. There was no agreement and/or best interest decision about this. A third person's capacity assessment was very basic and did not demonstrate their capacity had been properly assessed.

The service was not acting within the legal framework of the MCA in ensuring capacity assessments and best interest processes were undertaken. This was a breach of regulation 11 of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. Some people's rights had not been fully protected as a result of this breach. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with regards to the Mental Capacity Act (MCA).

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People provided mixed feedback about the quality of care. Most people said their needs were met by the service. One person said "[Relative] has dementia and challenging behaviour, she is very settled, we have consistency and quality." However, a number of people said they did not always receive appropriate care or

experience good outcomes.
• The service assessed people's needs prior to using the service and put in place a range of care plans. However, some care plans and risk assessments did not have enough details to demonstrate people's needs had been fully assessed.
• In most cases we saw evidence people's choices and views had been incorporated into care planning.
• The service needed to ensure that guidance such as from the National Institute for Health and Care Excellence (NICE) and Mental Capacity Act (MCA) guidance was used to inform practices such as relating to medicine management, capacity and consent.
• The service was not consistently delivering care in line with legal requirements as we identified seven breaches of regulation during this inspection.

Staff support: induction, training, skills and experience
• Staff received induction training, undertook a period of shadowing and were provided with regular training which was mostly kept up-to-date. However, the service needed to ensure greater continuity of staff to ensure staff built up detailed knowledge of the people they were caring for on a daily basis.
• People provided mixed feedback about the skills and experience of staff. Whilst some people said they had regular carers, a number of people said there were regular staff changes which was a problem as this meant carers did not know their routines, plans of care or where things were in their houses.
• Comments included: "I would like the same people. New ones don't know where everything is." "I would love the same people. I sit here wondering who is coming and when. At the weekend god knows whose coming." We saw some people had between 20-25 different care workers in a month. Recent analysis by the provider showed that 42 staff had left in the first 3 months of the year which reduced continuity further over a longer period of time.
• Staff received regular spot checks and some supervision and appraisal. However, supervision and appraisal were not always kept up-to-date. For example, in the seven files we looked in, only one staff member had received an appraisal in the last 12 months.

Supporting people to eat and drink enough to maintain a balanced diet
• Staff did not consistently provide the required support that met people's individual needs.
• Most people we spoke with said that they were provided with appropriate mealtime support. This included cultural appropriate food where required.
• In most cases, information in care plans guided staff on the support to provide.
• However, we found one instance where appropriate action had not been taken following a person's repeated refusal to eat. Nutritional care planning for this person was not adequate. We also found another instance where staff were not following the agreed plan of care in terms of consistency of food. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address these issues.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• Most people said healthcare needs were met by the service. One person said "[relative] had a urine infection and the noticed straight away and called the doctor."
•There was some evidence in care records of working with other professionals, including social workers, district nurses and GPs. For example, the service had referred to the speech and language team (SALT) where concerns were raised about a person's nutritional status. However we found this was not consistently the case.
• Appropriate action had not been taken to follow up on a deterioration in one person's health resulting in hospital admission. We spoke with their relative who was very critical of the support provided by the service. In addition, the service had failed to arrange for the review of another person's nutritional needs with the

relevant professionals after their family had stated the person's capabilities had changed. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address these issues.

Requires Improvement

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

At the last inspection this key question was rated as Good. At this inspection this key question has now deteriorated to requires improvement.

This meant people did not always feel well-supported, cared for or treated with dignity and respect.

Ensuring people are well treated and supported; respecting equality and diversity
We identified seven breaches of regulation during the inspection. This demonstrated that people did not always receive acceptable standards of care and support and demonstrated the service was not consistently treating people fairly and respecting equality.
• Most people said care staff were kind and caring and treated them well. One relative described the carers as "excellent" and very "receptive" to their relative's needs. They also stated, "they interact with her and are patient and understanding, they know her ways and how to work with her."
• People for whom English wasn't their first language said staff communicated effectively with them and they sent staff who also spoke their language where possible.
• A number of people said the quality of staff was inconsistent. For example, one person said they had banned a large number of carers from visiting, as they did not always speak to their relative appropriately, chatted between themselves and talked on their phones.
• We found the number of different care workers which people experienced did not always promote dignified or person-centred care. One relative told us "There are lots of different carers, why can't we have the same carers it is not good for relative." They explained that their relative was non-verbal and used non-verbal communication methods which it took time for staff to understand. Records showed they had 21 different care workers in April and 25 in May. We concluded therefore that in this example the provider had failed to recognise the human rights of this person in line with the protected characteristics of the Equalities Act legislation (2010).
• We saw other people had similar experiences. For example, one relative told us "new staff do not know [relative] very well, she has complex needs and I work and look after my relative so inexperienced staff impacts on my life as well." We concluded the number of different staff people had experienced meant this compromised the quality of care and meant it was not always person centred.

The lack of consistency of staff and experiences some people told us about demonstrated the service was not consistently providing person centred care. This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities 2014) Regulations. Some people had experienced poor outcomes as a result of this breach. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified.

Supporting people to express their views and be involved in making decisions about their care
• People generally said they felt involved in their care. One person said [care co-ordinator name] comes to

see us to update and review the plan we have a discussion about it and write it down. They come every six months."
• We saw evidence of regular reviews which included in person and over the telephone. The new managing director had also made efforts to meet and engage with people to try and understand any problems they had an improve their care experiences.
• However, a number of people said they felt no longer able to engage with the service due to long standing problems which had not been resolved.

Respecting and promoting people's privacy, dignity and independence
•Most people said they were treated with dignity and respect by staff. One person said, "The carers are very nice and polite, helpful and do the right things." Another person said "Most are nice girls. One is moody, I've told her not to come again but she does."
• Some people said staff did not always have the required attention to detail and/or respect them because they did things such as: leaving protective gloves in the garden, putting waste in the wrong bins, not cleaning up after themselves and compromising the cleanliness of the kitchen and fridge. We saw some daily records were not respectful and therefore did not promote people's dignity. For example, in one person's daily records, information about their bowel movements were documented in large letters across several lines of daily notes. There was no reason indicated in the person's care plan for staff to note in such a manner, and this information should have been documented in a way that upheld people's basic human right to dignified and respectful care.
• Care planning included information on how to maintain people's independence.

Requires Improvement

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

At the last inspection this key question was rated as requires improvement. At this inspection this key question has now remained the same at requires improvement.

This meant people's needs were not always met.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences; End of life care and support

• People provided mixed feedback about the quality of the care provided. Most people were happy with the care and the staff that provided it saying care needs were met. One person said, "They have been good but there have been lapses when they've not done what I want them to do." A number of people cited poor continuity of staff and variations in the quality of staff as a barrier to high quality care and support.

• People had care plans in place. These provided information to staff on the required care and support with some of this information being very detailed. However other care plans were lacking key information. For example, one person had a cough assist machine however there was no mention of this within the care and support plan to guide staff. Staff were taking blood sugar levels for another person but there was no guidance on this and what to do with the results.

• We saw most people received care visits at appropriate times and staff completed required tasks. However, we found a number of examples where staff had not stayed the allocated duration of the call. One relative told us staff were not completing tasks properly and were rushing compromising the quality of care. We saw their call times were shortened. Other records showed that staff arrived at approximately the same time each day, however staff did not always stay with people for the full call time. For example, we saw some call times were 7-8 minutes instead of 15 and others were 16-19 minutes instead of 30.

• We did not see evidence the service had sought information on people's end of life care needs of future wishes. Care plans lacked information about future wishes and advanced care planning. We raised this with the management team to ensure it was addressed.

This was a breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people had experienced poor care and support as a result of this breach. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified, to protect people from harm.

• Reviews of care and support were in place and included the person or their family. We saw evidence of actions taken as a result of these reviews, such as altering a person's care package to reflect their changing needs. However particularly where people had capacity, we saw often their relatives' views rather than their views were recorded.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to

follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.
• More information was required in some people's care files to fully evidence the service was complying with the standard and recording each person's communication needs. For example, one person's care records indicated they were deaf and did not wear hearing aids. However, there was no information about how staff should support or communicate with the person in relation to this when providing care
• The service could produce some documents in other formats such as large print and other languages if required.

Improving care quality in response to complaints or concerns
• A complaints system was in place: however, people provided mixed feedback about its effectiveness. Some people said their complaints had been addressed and things were improving. One person said "things have calmed down a lot, there are still lots of issues, but they seem more on the ball, everything is running smooth now, but I don't know how long it will last. However, five people told us that they did not see the point in complaining anymore due to either the way they were treated or the fact that things would not improve.
• We saw one person's care package had been terminated. However, no written or verbal explanation had been provided to the person in receipt of the care detailing the reasons why their care package had been terminated.
• Information on how to complain was present within people's homes. Complaints were logged, and we saw evidence of actions taken within required timescales to address individual comments and complaints. However, there was a lack of robust analysis of complaints to look for themes and trends.
• We reviewed complaints records, there were a number of trends around different elements of care quality, however, there was no evidence of reviewing these to improve the service. The new managing director told us this was something they were looking at introducing.

This was a breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people had poor experiences which affected their wellbeing as a result of this breach. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with complaints.

Inadequate

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At the last inspection this key question was rated as Requires Improvement. At this inspection this key question has now deteriorated to Inadequate.

This meant there were widespread and significant shortfalls in service leadership. Leaders and the culture they created did not assure the delivery of high-quality care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements; Continuous learning and improving care;
At our last three inspections the provider had failed to ensure effective governance arrangements were in place. This was a breach of regulation 17 (Good Governance) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection the service continued to be in breach of regulation as we found widespread concerns.

• This was the fourth inspection in a row where the service had been in breach of Regulation 12 (Safe Care and Treatment) and Regulation 17 (Good Governance). This demonstrated systems to act on our feedback and improve the service were not effective.
• We identified seven breaches of regulation during the inspection demonstrating widespread failings and a deterioration since the last inspection. These should have been prevented from occurring through the operation of robust systems of governance and audit.
• Some audits of daily record sheets and MAR sheets took place. However, these were not consistently completed and had not identified the issues that we identified during the inspection. The was a lack of audits and oversight where staff handled money for people. For example, one person did not have financial transaction sheets in place and the service was not aware of this.
• There needed to be better oversight of staff records such as recruitment files to ensure the required information was present. Systems needed to be operated to bring staff appraisals up-to-date.
• Care plans were not always up-to-date and did not demonstrate a robust assessment of people's needs had been carried out. This should have been identified through systems of quality assurance.
• There was a high turnover of staff and there was a lack of analysis to the reasons for this, and lack exit interviews to establish cause and reduce turnover in the future. A number of people complained about the lack of continuity of care workers.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. As a result of this breach a number of people had experienced poor care experienced, been placed at harm or experienced harm. In light of these concerns we asked the provider to send us an action plan immediately following the inspection stating how they were taking action to address the issues we identified with governance, to protect people from harm.

• The new managing director had been brought in to help improve the service. A number of people said they were having a positive effect on the service and helping it to improve. We found them to be open and honest with us about the service. They demonstrated they had plans in place to improve the service and had written a service improvement plan.
• Staff received regular spot checks, and these had been increased to help improve the quality of the service. These had been increased as a result of some of the care quality concerns.

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
• We identified a number of breaches of regulations which demonstrated the service was not consistently treated people in a fair and inclusive way and achieving consistently positive outcomes.
• People provided mixed feedback about the overall quality of the service and management. Most people were happy with Caremark as a care provider. However, there was a sizeable minority who were unhappy with the quality of the care and support they received, particularly the lack of continuity of staff, and variations in the quality of staff and management not always listening to them and dealing with their complaints. One relative said, "It's been an absolute nightmare, they know how to sweet talk you, they say they are doing everything, but they are not." Another relative said "It is management that is the issue, no feedback from management, get so frustrated I have given up with them."
• Most staff that we spoke with said they were happy working for the service. They said they felt listened to by management and well supported. Staff said they were treated fairly, and any diverse needs were catered for.

• The new managing director was open and honest with us about the quality of the service and the direction in which they wanted to take the service. We saw they had made efforts to engage with people and some people provided positive feedback about this.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
• ` Basic analysis took place however we did not see evidence of actions being taken as a result of the results of the recent service user or staff survey, some of which expressed concerns about some staff professionalism and staff staying the right amount of time, which matched some of our findings showing it was still an issue.
• The new managing director told us they were in the process of sending out a new survey and would complete a 'you say, we did' response which they intended to share with people.

• We saw the new managing director had written to every service user when they started, to introduce themselves and request feedback from people about the service.

• Regular staff meetings took place and we saw these were planned quarterly for the coming year. Meetings covered a range of topics, including medication, punctuality, infection control and staff staying the full length of time at calls.

Working in partnership with others
•The service attended events run by the local authority and their partners to network with other providers and share practice
• The service was under enhanced monitoring by the local authority because of the nature of the widespread concerns and was sending updates to the local authority on a daily basis to let them know how the service was performing.