Carewatch Care Services Limited

Carewatch (Dereham)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This was an announced inspection that took place on 26 and 28 April 2017.

Carewatch (Dereham) is a service that provides personal care to people in their own homes. At the time of the inspection over 300 people were receiving support from the service.

There was no registered manager working for the service. 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 and associated Regulations about how the service is run. The last registered manager de-registered with us in January 2017. A new manager who was currently working as the provider's regional manager had been employed by the provider to run the service. They told us during the inspection they would be applying to register with us.

At our last inspection in August 2016, we found that the quality and safety of the care being provided to people required improvement. We identified that the provider was in breach of three regulations of the Health and Social Care Act 2008 (Regulated Activities) 2014. This was because they had not employed enough staff to meet people's needs and preferences and that their governance systems were not effective at improving the quality of care people received. At this inspection, we found that the required improvements had not been made. This has resulted in five breaches of the Health and Social Care Act 2008 (Regulated Activities) 2014. You can see what action we have told the provider to take at the back of our report. Full information about CQC's regulatory response to any concerns found during inspections is added to reports after any representations and appeals have been concluded.

There continued to not be enough staff to meet some people needs and preferences. Although some people had regular staff who provided them with good quality care, this was not the case for all people. Some people experienced missed, late or inconsistent calls that impacted on their daily lives. Some also saw a number of different staff which meant they could not build caring or trusting relationships with them.

Where staff were asked to provide care to people they did see regularly, they did not always have the correct information to hand to tell them about the care people needed. Therefore, there was a risk these people could receive unsafe or inappropriate care that didn't meet their needs.

Some people's complaints or concerns had not been acknowledged or investigated. Where they had, these had not always been listened to or the quality of care people received had not changed. Incidents that had occurred or that staff had become aware of, had not always been recorded and investigated. This resulted in missed opportunities for the provider to improve the quality of care some people received.

The provider's governance systems to assess and monitor the quality of care provided were not all effective. Since our last inspection, there had been a lack of impetus from the provider to drive improvement within

the service. A new manager had been recruited who had comprehensive plans in place to improve the quality of care people received.

People who required support with eating and drinking and maintaining their healthcare received this. The staff were kind and caring and treated people with dignity and respect. People could make decisions about their care but the facilitation of their involvement in this could be improved. Consent had been obtained from people in line with the relevant legislation.

The staff were happy working for Carewatch (Dereham). They felt supported and knew how to reduce the risk of people experiencing abuse. They felt that the quality of care being provided to people was improving.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

There were not enough staff to meet all people's needs.

Risks to some people's safety were not being managed effectively. Incidents or accidents were reported but some had not been investigated.

The systems in place to ensure people received their medicines when they needed them required improving.

Staff were aware of how to protect people from the risk of abuse.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The staff had received supervision and training but a number of people did not feel they had the right skills to meet their needs.

Consent was obtained from people in line with the relevant legislation.

People were supported to eat and drink enough to meet their needs and to maintain their health.

Is the service caring?

Requires Improvement

The service was not consistently caring.

The staff were kind and caring. However a number of different care staff provided some people with their care which made it difficult for them to build caring and trusting relationships with them.

People were able to make decisions about their care but had not always been given the opportunity to do this face to face at the frequency required by the provider.

People were treated with dignity and respect and their privacy was maintained.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not all people's care was being planned and delivered to meet their individual needs and preferences.

People knew how to complain but their complaints and concerns were not always being investigated or dealt with appropriately.

Is the service well-led?

Inadequate

The service was not well led.

The governance systems in place had not been effective at driving improvement within the service. This resulted in some people continuing to experience poor quality care.

Past leadership had been poor but a new structure was in place to improve the quality of care people received.

Carewatch (Dereham)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 26 and 28 April 2017 and was announced. The provider was given over 24 hours' notice before we visited the office because the service provides care to people within their own homes. The provider and staff operated from a central office and we needed to be sure that they would be on the premises so we could speak with them during the inspection. The inspection team consisted of two inspectors and two experts by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The inspectors visited the provider's office and the experts by experience gathered feedback from people and their relatives over the telephone.

Before the inspection we reviewed information we held about the service. This including looking at notifications the service had sent to us. Services have to, by law, send us certain information in relation to incidents or accidents that occur. We also reviewed information we had received from the local authority quality assurance team.

During this inspection, we spoke with 27 people who used the service and nine relatives of people who received care from Carewatch (Dereham). We also spoke with ten staff, the deputy manager, the regional and the operations manager who represented the provider.

We looked at the care records and risk assessments of ten people who used the service, four staff recruitment records and information in relation to staff training. We also looked at how the provider monitored the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in August 2016, we found that there were not enough staff to meet people's care needs. This had resulted in some people not receiving their care calls as agreed or the staff visiting them late. This resulted in a breach of Regulation 18 of the Health and Social Care Act (Regulated Activities) 2014. At this inspection we found that sufficient improvements had not been made.

Twenty of the 36 people and relatives we spoke with told us they had experienced either missed, late or inconsistent calls from the staff. People said that weekends were a particular issue. One person said, "There have been about five occasions over recent times. About half where they have either not turned up at all in the morning and half where they have turned up too late, about an hour and half late." Another person said, "I don't know what time to get up in the morning to get ready for them. You're told 8.30am to 9am and then they turn up at 7am." A further person told us, "There is never a problem when my regular staff are here, but it is very pot luck when my regular carer has a day off. Then the staff are late or not at all. I am missed. I struggle a bit then and try to do my own care. The agency don't make cover for staff when they are absent so someone has to come in from another area."

A relative said, "They (the office staff) have said 'We are in an awful muddle, can you do her?' Its fine if I know in advance but they don't let me know until last minute when I've got my plans or even already gone out. There have been times I've gone out only to find [family member] still in bed at midday." Another relative said, "They do not have enough care staff and if somebody is off sick they can't cope. The times recently have been up and down like a yoyo. I actually think its management not the girls."

Three of the nine people or relatives who commented on whether staff stayed for the required amount of time told us they did. However, six said they did not. One person said, "Some (staff) rush when doing it (providing care). It should be 30 minutes in morning and evening but they often only stay for 15 minutes in the evening. A particular carer this week only spent 10 minutes with me in the evening. She said she was very busy and just disappeared. They are short staffed." Another person said, "The staff don't stay the correct length of time. Only 10 minutes on occasions for the teatime call when it should be 30 minutes. They don't take the time to chat which would be nice." A further person told us, "The lady who comes at night doesn't do her full time. She is in and out quickly but at least she gets me to bed." A relative said, "Some of their visits are really short. The shortest has been six minutes." Another relative told us, "At the weekends they don't always stay the full half hour and [family member] will often say that they were only here for about 15-20 minutes." Some people's records we checked confirmed that staff did not always stay for the required length of time as agreed in their care contract.

One relative told us their family member required two staff members to support them with their care needs but said that on occasions, only one staff member had turned up. They told us the impact this had on them. They said, "It should be two carers at the morning visit but Carewatch have only sent one carer. I used to help if they only sent one person. I'm elderly myself and it is too much." We checked this person's record in relation to the care calls they had received and found that one staff member had only provided care to them for some visits. The regional manager told us that two staff should always attend this person.

The staff we spoke with told us they felt that since our last inspection, improvements had been made and that they had not missed any care visits. They also said that on their care rounds, always two staff always attended people where this was required. However, some of them did say that they sometimes got asked to cover extra visits that had no staff allocated to them. They said this was a particular issue at the weekends although they said the frequency they were asked to do this had decreased over recently. Some said this was not an issue as they could fit in extra visits to their day. However, others said that the extra visits did not always leave them with an adequate gap between calls and that therefore, they were sometimes late and could not always spend the required amount of time with people. One staff member told us about a person who required their visits early in the morning so they could go out. They said they were aware that this was not always happening and therefore, the person cancelled some of their visits and tried to manage themselves. Another staff member told us they were not able to schedule care visits to meet people's preferences due to not having enough staff to meet these needs.

We saw from the regional manager's quality improvement plan (QIP) that in March 2017, care staff were only able to cover 70% of the required care visits. This left 30% requiring allocation. Existing care staff, bank staff and staff who worked in the office had all been utilised to cover these calls. This resulted in some of the original 70% having to have the times of their calls moved or adjusted to enable the other 30% to be fitted in. Some of the office staff, which included quality monitoring officers, confirmed that they were used to cover care visits, particularly at weekends. This took them away from their office and quality monitoring duties, leaving the office short of staff on occasions. The regional manager had documented in their QIP in March 2017 that the care staff did not have capacity to pick up extra visits at short notice for example if a staff member called in sick. One person had told us in February 2017 that they had received a letter from the service telling them that due to staff sickness, the weather and traffic issues that their care visits would be up to an hour either side of their preferred time. Although this is pro-active in informing people of current pressures on the service, this along with the other evidence presented demonstrated that the service did not always have enough staff to meet people's individual needs and preferences and that there was a lack of robust contingency plans in place to cover unplanned staff absence. The operations manager confirmed to us that currently office staff had to cover some care visits, particularly at the weekends due to a lack of care staff being in place. This was a continued breach of regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The regional manager told us they had recognised that staffing levels were an issue when they had commenced working for the service, particularly at the weekends. A recruitment drive had therefore been in place which had resulted in a number of new staff being employed by the service. The regional manager emphasized that they only took staff with the appropriate attitude and/or experience. Some of these new staff were currently going through their training. The operations manager told us that this remained a primary focus of the provider and that a dedicated recruitment officer was due to shortly join the team in an attempt to recruit further staff. They also told us that office staff had received further training in January 2017 in relation to scheduling calls and that care staff working hours had changed. These had both been conducted to reduce the number of inconsistent and late calls that people had experienced.

At our last inspection in August 2016, we found that the information documented within people's risk assessments needed improving. This was because some did not hold sufficient information to guide staff on what actions they needed to take to reduce the risk of a person experiencing harm. At this inspection we found that the necessary improvements had not been made.

Some staff told us they sometimes visited people who they were not familiar with. Therefore they were reliant on accurate and up to date information being provided to them so they could give people safe and appropriate care. Some staff told us this was an issue and that the records they were provided with were not

always correct. One staff member said that sometimes they 'went in blind' and had to rely on the person or relatives advising them what care was required. This placed people at risk of receiving potentially unsafe care. When we looked at people's records, we saw that the information and guidance provided to staff in relation to how to manage risks to people's safety was not always sufficient.

For example, we saw that one person required a hoist to support them to move. There was limited information within the moving and handling risk assessment to guide staff on how to use this piece of equipment safely. Staff were advised to ensure that the sling 'fitted correctly' but no other information had been recorded. We spoke with a staff member who supported this person with their care. They told us that the person was at risk of choking on their tablets. They said they had spoken to the person's GP about this who had advised them to halve certain tablets to reduce this risk. No assessment of this risk had been undertaken in relation to this matter and this information had not been documented within their care record. We asked the regional manager about this. They told us that if the information was not within a person's care record, that staff had access to further information on their phone. We checked the information about this person that would appear on a staff member's phone. There was no mention of this risk. The regional manager agreed to immediately update the person's care records, risk assessments and the information available to staff on their telephone's to reduce the risk of this person receiving unsafe care.

The staff had assessed another person as being unable to move independently. This meant they spent their time either in bed or in a chair. Due to this, they had some pressure equipment in place that included an air mattress and a pressure cushion to reduce the risk of them developing a pressure ulcer. However, there was no information regarding what setting the air mattress should be on so staff could check that it was effective at reducing this risk. There was no guidance to specifically tell staff when the person needed to use the specialist cushion. Although a risk assessment in relation to tissue viability was indicated as being required, one had not been completed. This person required a hoist to support them to move. There was no information noted within the moving and handling risk assessment advising staff what they needed to do to ensure this was completed safely.

The regional manager told us they were aware that people's care needs and risk assessments required reviewing. They said that a plan was in place to review all of these by end of June 2017 to ensure they were accurate and provided staff with sufficient guidance on how to mitigate risks to people's safety.

The regional manager told us that all incidents and accidents that occurred had to be reported to the office for investigation. The staff we spoke with were aware of this and told us how they would report any incident to the office. However, during the inspection we were made aware of two incidences in respect of potential medicine errors that had been reported but not investigated. A staff member told us they had found gaps in one person's medicines record recently and that they had reported this omission to the office. A relative also told us of a recent incident where their family member had not received their medicines correctly. They stated they had contacted the office twice about this and had spoken to the office staff about the error. The regional manager checked these people's records but there was no note of these conversations having taken place. The regional manager agreed to immediately investigate both of these incidents.

The service kept records of missed visits. At total of ten had been recorded as having occurred in the six months prior to our inspection. Each of these had been investigated and were found to be due to either a communication or scheduling issue. The regional manager told us they were reliant on staff or people using the service contacting them to report a missed call. However, care was being provided to some people who may not have been able to do this. Therefore there was a risk that the service may not know if some people had missed a care visit.

We have concluded that risks to people's safety were not always being assessed or managed effectively. Staff did not always have appropriate or accurate guidance to help mitigate the risk of people receiving unsafe care. This was a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The regional manager told us that staff were giving medicines to 66 people at the time of our inspection. Most of the people we spoke with who were receiving support with their medicines told us they received them when they needed them. One person told us, "I have help with my tablets." A relative said, "They give [family member] tablets and make sure she has swallowed them." However, one relative said they were not confident their family member always received their medicines correctly.

All of the staff we spoke with told us they had received training in how to give people their medicines safely. They also said that their competency to do this had been assessed recently. The staff files we looked at confirmed this.

We checked six people's medicine administration records (MAR) that were held in the office to see if they indicated that people had received their medicines correctly. We found gaps in four of these people's MAR where staff had not signed to show that the medicines had been taken. Two of these were MAR were from January 2017 and another from December 2016. When it was brought to their attention, the regional manager cross-referenced these gaps against notes made by the care staff during their visit to the person's home. These confirmed that the person in most cases, had been given their medicines but that a record of this had not been made as is required.

When asked, the regional manager was not able to provide any evidence to demonstrate whether these MAR had been audited so that these issues could have been identified and investigated. They told us that currently, 10% of people's MAR were to be audited each month. However, some of the staff who were responsible for this told us they were behind with auditing these records. For the people whose MAR we looked at, the regional manager was not able to tell us when their MAR had last been audited. We saw that a document was in place that captured this information but the regional manager told us that at the time of the inspection, it did not provide an accurate picture. They said this was because it had not been updated during their period of absence from the service.

We also found that one person, had not received their prescribed medicine, Paracetamol, as often as they should have done. The staff were omitting to give it to them during their teatime visit. We spoke with the staff about this. They told us the person did not want to take the medicine at this time and therefore, they did not give it to them. Another person was receiving their Paracetamol four times per day on a consistent basis although it had been prescribed as an 'as and when' (PRN) medicine. In both instances, these people's GPs had not been contacted so they could review these people's medicines to make sure they were appropriate for their current needs. The regional manager agreed to do this.

Where the staff supported people with the application of creams, guidance was provided to them on how to do this correctly. This was a pictorial guide for staff showing them where they needed to apply the cream. However, where a medicine had been prescribed as PRN, no protocols were in place to guide staff on how and when they needed to administer these medicines to people. The regional manager confirmed these were not being used and they had not assessed whether people needed these in place. They agreed to review this immediately.

Therefore, improvements are required in the way people's medicines are monitored so the provider can gain assurance that people are receiving their medicines correctly and can identify and address shortfalls in a

timely manner. The regional manager said that at the time of the inspection, they had commenced auditing all of the MAR they held in the office and that going forward, all MAR would be audited each month.

All of the people we spoke with told us they felt safe when the staff were in their homes providing them with care, particularly if they were their regular carers. One person told us, "I do feel safe with them generally." Another person said, "I feel safe with my regular carers. They are friendly and do what they can for me. I feel that they know what they are doing so I feel safe."

Seven of the nine relatives we spoke with agreed with this. One relative said, "I do feel that [family member] is safe with the carers especially the regular ones." Another relative told us, "I do feel that [family member] is safe with the carers we have at the moment." However, two relatives did not think their family member was safe. One of them told us, "Most of them aren't bad girls but they are not trained very well and are not very observant. You are constantly on guard and checking on them." Another relative said, "Some I wouldn't feel confident leaving him alone with them."

All of the staff we spoke with were able to tell us what abuse was and how they would report it if they had any concerns. This included to the relevant agencies outside of the service if required. We saw that where safeguarding issues had been raised with the regional manager, that these had been dealt with appropriately.

Before staff started work, a number of recruitment checks had been made to establish whether they were of good character and were safe to work within a care environment. These included the verification of staff identity and a Disclosure and Barring Service (DBS) checks. However, out of four staff files we looked at, two members of staff did not have a record of their full employment history although the application form requested this information. We reported this to the regional manager who advised that all staff files were currently being reviewed as part of their improvement plan for the service. After the inspection visit, the regional manager told us that one staff member had been subject to a transfer from a previous employer under the Transfer of Undertakings (Protection of Employment) Regulations 2006 and that therefore, they were not able to retrospectively go back to collect or check this information.

Requires Improvement

Is the service effective?

Our findings

At our last inspection in August 2016, we found that the staff's competency to perform their role effectively had not been assessed at intervals in line with the provider's requirements. At that inspection, we concluded that improvements were therefore required within this area. At this inspection we found that the required improvements had been made and that staff competency had been recently assessed. However, we received mixed feedback from people and relatives regarding staff competence to perform their role.

Of the 13 people who gave us feedback on this topic, five said they thought staff were well trained, five disagreed and three told us they were not sure. Of the five relatives, three said staff were well trained but two disagreed. Most people were satisfied that their regular staff had the skills and knowledge to provide them with effective care. However, where people were visited by unfamiliar staff, they did not always feel this was the case. One person told us, "My regular carer is very experienced." Another said, "I feel the staff have enough training to meet my needs" However, another person told us, and "If there is anybody new I have to train them. I use a lot of equipment like the hoist so I have to teach them how to get me onto it. A lot of the training is down to me. I don't think they get enough training." Another person told us, "It takes them longer as they have to keep asking me what to do. One carer did come in with another new carer. I think she was shadowing." A relative said, "I don't feel that they always know what they are doing. I don't think they get enough training. I really don't think they get much training on dementia."

All of the staff we spoke with told us they felt they had received enough training and supervision to provide people with effective care. They said they had received training in a number of areas including but not limited to; assisting people to move, dementia, the Mental Capacity Act 2005, infection control and health and safety. They said they could receive extra training if they wanted it and that the provider was very supportive in this area. The new staff we spoke with said they had been fully supported when completing their induction training. This included shadowing a more experienced member of staff. One new staff member said they had received extra shadowing when requested to help them improve their confidence. The staff training records we saw showed that they completed a comprehensive five day training programme when they started to work for Carewatch. Their competence to perform their role safely and effectively had been assessed by an experienced member of staff before they were able to work on their own.

The regional manager had a record of all of the training and supervision staff had completed. We saw that training was overdue for some staff but the regional manager told us that these staff had been booked on refresher training. Seventy-three per cent of staff had now received some form of formal supervision which was an improvement since our last inspection. The regional manager told of us that their plan was to provide all staff with some form of supervision within the near future.

We have concluded that in view of the feedback we received from people and their relatives about staff training and competency, improvements are required within this area.

At our last inspection in August 2016, we made a recommendation to the provider regarding the application

of the Mental Capacity Act 2005 when providing care to people who may not be able to consent to it. We made this recommendation because we found that some staff were not clear how this important legislation affected their care practice in these circumstances. Also, the documentation in people's care records in relation to their capacity had not always been completed. At this inspection we found that some improvements had been made.

All of the people we spoke with and most of the relatives told us the staff sought their or their family member's consent before performing a task. One person told us, "Permission is gained before any care is started." A relative said, "The staff ask permission."

All of the staff we spoke with demonstrated they understood how to support people in line with the MCA where they were unable to consent to their care. Staff explained how they always offered people choice and supported them to make decisions. This included showing them what different clothes they could wear or food they could eat. Some staff told us how they supported people with personal care who may be reluctant to participate in this. The staff were aware that any decisions they made on behalf of the person had to be in their best interests if they were unable to consent to the care themselves.

People's care records contained some information about their ability to consent to their own care. This included information about their capacity and whether they had an advocate who could legally do this on their behalf. However, due to some people's care needs not having been reviewed recently, we found that some people's care records had not been updated to show they lacked some capacity to make certain decisions about their care. The regional manager told us they were aware of this and that these needs were being reviewed and would be completed by June 2017.

Most people we spoke with who were supported by the staff with their eating and drinking were satisfied they received sufficient choice and that staff prepared their food and drink to their liking. One person told us, "The staff make me a cup of tea, and some porridge. And then they make me a sandwich for lunch." Another person said, "The staff get my breakfast and make me a cup of tea. When the staff come back at lunch time, I have a good lunch and they ask me what I want to eat." However, one person and one relative did not agree with this. One person said, "Also the way they cook meals. They push you into ready cook meals because they haven't got time to cook meals. You don't get the choice to have a freshly cooked meal." A relative told us, "Looking at the logs I noticed that [family member] didn't have a single hot meal over the Easter weekend when I wasn't around. Only toast and sandwiches. [Family member] needs to be encouraged to eat. No wonder she loses her appetite."

The staff we spoke with demonstrated they understood the importance of making sure that people ate and drank sufficient to meet their individual needs. One staff member told us how they always ensured the people they saw regularly were left with something to drink. Another staff member said they ensured they left a person a snack as they were aware that they often refused to eat their lunch. Staff also told us they involved other healthcare professionals when needed if they were concerned about someone's eating and drinking, for example a GP or dietician.

For those people staff saw regularly, they were able to tell us about their food and drink likes and dislikes. However, we saw that this information was not noted within people's care records. How people liked to have their meals prepared was also not documented. This would provide staff with the necessary guidance if they were not familiar with the person's needs. The regional manager advised this information would be added when people's care needs were reviewed.

Most people we spoke with arranged their own healthcare. However, they said they were confident staff

would help them do this if needed. One person told us, "I had a chest infection and the carers reported this to the office. The manager came out and they helped me get to hospital." Another person said, "I fall over a lot and they did once find me on the floor. They called an ambulance and stayed with me until it arrived."

All of the staff we spoke with demonstrated they had a good understanding of the different types of healthcare professionals who could be contacted to help people maintain their health. These included GPs, opticians and district nurses. We were therefore satisfied that staff supported people to maintain their health.

Requires Improvement

Is the service caring?

Our findings

At our last inspection in August 2016, we found that people were not always able to build caring relationships with staff. This was because some people's care was provided by a number of different staff. People had commented that they often did not know who would be providing them with care. The provider told us at that inspection that they had recognised this issue and were making improvements within this area. However, we found that sufficient improvements had not been made.

Most people told us that they had regular carers for some of their care visits which they liked but they said that for other visits, or particularly at weekends, they often saw a number of different care staff. They told us this was issue for them. One person told us, "I get a regular carer in the mornings but all different carers in the evenings. In the evening all she has to do is cream my legs but often they are not so friendly and don't sit and have a chat with me." Another person said, "My regular carer is great and will tell me when she is coming but when she is off they get in a bit of a muddle. Last week they sent a man and I've told them before that I don't want a man. I phoned and they said they'd sort it out. I don't know whose coming and what time when my regular carer is off." A further person told us how they had built up a good relationship with their regular carers but said they had recently stopped coming. They said they had not received any explanation for this and that now they were seeing a number of different care staff. They told us, "If I could just have [my usual] on a regular basis my life would be so much better and easier. They would come and have a lovely chat with me. It really helps. Others just seem to want to come in and get out quickly. It would be nice for them just to have a little chat with me."

The relatives we spoke with agreed with this. One relative said, "She does have regular carers and there is one that she gets on with very well. They have a good attitude with her. They have got to know her and know how to approach and encourage her. Weekends can be difficult though as it can be all different people. They can send a completely unknown girl especially at weekends and on a Sunday morning." Another relative told us, "My wife likes them and generally gets on with the girls. They send a man too sometimes to help her wash but she doesn't mind that and she likes him. They always send a woman with him. They laugh and joke with her." A further relative said, "There are about five or six different people she will see. She has dementia and so this lack of continuity is difficult" Some people's records we viewed confirmed this. One person had seen 15 different carers and another 10 for their morning visits during one week in April 2017.

The staff told us that they did have people they visited on a regular basis. This they told us this enabled them to build up good relationships with people. However, they said they were also asked to see other people that were not usually on their care round. They were not introduced to these people before they saw them.

The regional manager was aware of this issue and told us that once all the required new staff had been recruited and trained that this area would improve. We have concluded that further improvements are required to ensure that people can develop caring and trusting relationships with staff.

Some people said they received a schedule for the week that told them which carers would be visiting however, other people told us they had not received the information they needed at the time they wanted it.

They did not receive information regarding which staff member would be visiting them and at what time. Some people told us they found this frustrating as it was important for them to know who would be providing them with care. We saws in the provider's survey that they conducted in February 2017, that 24% of people said they never knew who was visiting them.

One person told us, "The main problem is that they don't give you enough information. They don't ring and tell me anything. I have to phone them always. " Another person said, "Sometimes I get a schedule sent to me and on my regular carers day off it says 'unallocated' and the time can be anywhere between 7.30am and who knows when. There have been a couple of times when the carer told me they'd been told to come at 7am on their roster. I phoned the office and they say 'Oh no that's not right.' I'd also like to know whose coming rather than just saying 'unallocated' on the schedule. It's an on-going bone of contention." A further person said, "Often I don't get a rota and I have to phone to ask who is coming and what time when my regular carer is off. In the past we may get a courtesy call to say what's happening but that doesn't happen now" A relative told us, "We used to get a rota each weekend but we don't get one now."

The regional manager told us they were aware of this concern. During the inspection visit, they showed us a letter they had recently sent to each person using the service. This asked them if they wanted a schedule sent to them each week. The regional manager assured us that those people who wanted one would receive one. They also said that people would be kept up to date with any changes made so they knew which staff would be visiting them.

People and their relatives told us they were satisfied they were able to make decisions and had choices about the care that was provided. They said they had been involved in the assessment of their care when they first starting using the service. People's care needs had been discussed with them along with any goals they had in relation to the care provided. They also said that staff regularly offered them choice when providing them with care and respected any decisions they made. One person told us, "I can make decisions about my care." Another person said, "They listen when I tell them what I need them to do."

One of the systems the provider had in place to facilitate people making decisions about their own care once it had started, was for them to participate in reviews of their care. These were due at regular intervals throughout the year and included face to face meetings or a discussion over the telephone. Of the six people and two relatives we discussed this with, four people said they could not recall being involved in a recent review of their care. One person told us, "Nobody from the senior people have been out to do a review or see how I am." Another person said, "In the first year or 18 months they did a review but nothing in recent times. Over the last two years I haven't seen anyone." In the provider's survey in February 2017, 62% of people said that a senior member of staff had not visited them to check the care they required met their needs and the provider's own figures for April 2017 stated that 52% had not received a face to face review as was required by them. However, the provider's report did state that 89% of people had received a telephone review.

The records we looked at showed that some people had been involved in a recent review of their care but not all. The regional manager agreed that this had not been conducted with the frequency it should have been but told us that all people would have had a face to face review by end of June 2017.

All of the people we spoke with and most of the relatives said the staff were kind, caring and treated them or their family member with dignity and respect. This was particularly evident for those people that saw the same staff on a regular basis.

One person told us, "I'm happy with the carers. They are all very kind to me." Another person said, "Most of the carers are the most wonderful people in the world. Most of them are angels without wings." A further

person told us, "The staff are helpful and respectful and speak nicely to me." A relative said, "I am sure the staff are caring because [family member] has never told me they are not. I see the staff being kind and they seem to be gentle. [Family member] is happy and they like them all. There is a good rapport." Another relative told us, "There is a rapport with the staff and everyone is friendly."

People and relatives also told us that their or their family member's privacy and dignity was always upheld and that people's independence was encouraged. One person told us, "They always close the curtains to protect my privacy." Another person said, "She [care staff] will encourage me to do what I can. She always uses towels to cover me as she helps me wash" A further person said, "If it wasn't for the staff I would be in a home and that is not happening. This way I remain independent in my own home." A relative told us, "I feel [family member] is safe and the staff always shut the door for any personal care."

The staff we spoke with demonstrated they cared about the people they supported. They knew the people they regularly supported well and understood their likes, dislikes and preferences. They were all clear about respecting people's privacy and dignity and told us they encouraged people's independence as much as possible. One staff member told us how they supported one person to walk during their visits as they knew this was important to them. We were satisfied that staff were kind and caring and treated people with dignity and respect.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection in August 2016, we found that care had not been planned or delivered to meet people's individual needs. Some people's care records contained insufficient information about their individual care requirements. This resulted in a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2014. At this inspection we found that sufficient improvements had not been made.

Thirteen of the people we spoke with told us they were happy that the care they received met their individual needs and preferences. Four of the relatives we spoke with agreed with this. However, fourteen people and five relatives told us this was not the case for them. These people and relatives said that on occasions the care visit were late or inconsistent which had an impact on their or their family member's daily lives. Both the people and relatives we spoke with told us they were frustrated at not always being told by the provider if the staff member was running late. We saw from the provider's survey in February 2017, that 43% of people said that staff only 'sometimes' arrived on time.

One person told us how it was important that staff turned up on time to prompt them with their medicines. This was because their medicine helped with their mobility. They told us, "I do self-medicate but they do just check that I have taken my medication as my memory is not so good now. It's got written on my pack what drugs I take and the times. If you look in my book some carers don't get here until 11.20am so if they are checking my medication that's too late. I do occasionally forget." We spoke to some care staff who provided care to this person and they confirmed that sometimes they arrived later than the person preferred. They said this had on occasions meant the person had received their medicine later than they required. Another person told us of a similar experience where they were required to have their pain medicine every four hours. Although they confirmed they received this they said that due to staff sometimes running late during the day, they often had to wait up to take their final pain killer for the day. This meant they could not go to bed when they wanted to.

Another person told us, "Sundays I have to go out but they never get to me early enough and so I have to get myself done. I do manage but once they always came at 7am which suited me. When my regular is coming she will tell me what time she'll be coming the next day and if I'm going out she'll come a bit earlier." We checked this person's records and found that most of this person's calls had been scheduled for 9.15am each morning. However, on occasions, particularly at weekends the times had varied from 7am to as late as 11am. A further person told us, "In the evenings my call time is 7.30pm, but some staff come at 6.30pm which means I am undressed too early." Another person said, "There are two carers needed on each call. No one can do me by themselves. Sometimes one turns up before the other and she has to wait. They are generally on time but it can vary for example, they are supposed to be here at 5.30pm and they turn up at 4.30pm. The office have always got an excuse about the times and are very disorganised. I don't want to go to bed early and then stay in a wet pad all night."

A relative told us how staff had sometimes turned up at 5.30am to provide their family member with care. Although they said they were not particularly inconvenienced by this as they and their family member were early risers, they said, "The normal time should be 8.30am to 9am. Weekends can be very bad with any time

from 7am until 11am. If only they would let us know the times." This person's records confirmed they were regularly receiving their care at inconsistent times. In the two weeks prior to our inspection, the care visit times had ranged in the morning from as early as 7am to as late as 10.30am. Their lunch call ranged from 11.45am to 2.15pm and tea from 3pm to 5.45pm. In March 2017, we saw that on one day they had received visits that had not been adequately spaced to support the person with their meals. A morning call had been made at 7.30am, lunch at 3pm and then tea at 4pm.

Another relative said, "[Family member] goes to a day centre twice a week and we have asked the agency to ensure that she is ready for 8.30am for the transport to pick her up. They need to prompt her and help her get ready, give medication and prepare her breakfast. Last Thursday I got a call from the day centre. Its lucky they know me otherwise she could have been left alone. They told me that when the transport arrived they found her undressed and bewildered. The carers hadn't been yet so they helped her get ready and took her and they phoned me and the pharmacy regarding her medication. I saw the day after that the carer had written in the log 'Sorry I wasn't in time; the office told me 9.30am'. It's not the first time this has happened and it creates a whole load of problems." Again, this person's records confirmed they had received care calls at inconsistent times in April 2017 ranging from 5.45am to 11am which was not in line with their preference.

We asked some people if they had been asked about their preferences in relation to the times staff provided them with care and the gender of the carer they preferred to provide them with support. Most people could not recall being asked these questions. One person said, "My regular carer is good and will tell me when she is coming but when she is off they get in a bit of a muddle. Last week they sent a man and I've told them before that I don't want a man. I phoned and they said they'd sort it out. I don't know who is coming and what time when my regular carer is off." We checked this person's record and saw that their preference for only female carers had not been recorded on their file although this had been previously raised as an issue. This meant there was a risk that the office staff would continue to allocate male staff to this person. Another person said, "They did send a man twice but I've told them I don't want them sending a man again and so far they haven't."

Some staff told us that there was enough information in the care records to enable them to provide care to people that they required. However, some said they didn't always have sufficient information, particularly if they were unfamiliar with that person's needs. They said when this happened they either had to ring the office for information or ask the person or relative for guidance.

Although people's care needs had been assessed before they started to use the service, regular reviews of their care had not taken place. This resulted in some people's care information being out of date or not reflecting their current needs. For example, some areas that were important to people were not documented within their care record. During this inspection, we found that for two people, the time they wanted to receive their medicines was not reflected within their care record. For another person, the fact they regularly attended a day centre had not been documented. One person's care record did not hold critical information or accurate information about their current needs. It stated that they were at risk of choking whilst eating food and therefore, staff needed to stay with them during this process if their relative was not present. However, staff confirmed this was incorrect and the person was actually at risk of choking on their medicines. Staff told us they were providing another person with forms of personal care that were not documented within their care record.

Some people's care records also continued to lack detail regarding what support care staff needed to give to meet these needs. For example, two people had a catheter and the instruction for staff was to 'check leg bag' but there was no further information to guide staff on what they needed to actually check and what

they needed to do if they found any issues. Another person required a diabetic diet but there was no information about how staff should prepare this diet and how to identify symptoms associated with diabetes. This placed people at risk of inconsistent or inappropriate care. The regional manager agreed that people's care records required more information in them.

The care records we looked at had documented some people's preferences. These were in relation to how the person preferred to be addressed and their preferred communication method. However, as we found at our last inspection, people's preferred visiting times and the gender of carer they wanted to provide them with care had not always been assessed or documented. This had resulted in some people receiving visits at inconsistent times and the incorrect gender of carer to suit their needs.

The provider had continued to fail to plan and deliver care to people based on their individual needs and preferences. This was a continued breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

The regional manager told us that they were aware of these issues. They said that plans were in place to capture people's individual needs and preferences in more detail during the review of people's needs which was currently being conducted. They said that improvements were being made to staffing numbers to enable people's needs and preference to be met. They also confirmed they had instructed the office staff to not move call visits unless absolutely necessary and then, to advise the person if this was the case.

At our last inspection in August 2016, some people and relatives we spoke with told us they had experienced difficulty in speaking to staff in the office or that any changes they wanted to make to their care had not been listened to. At this inspection, we received mixed views from people about how responsive the office staff were to them. One person told us, "I speak to the office, the staff listen and act on what I ask." A relative told us, "I've spoken with the agency and they listen." However, some other people and relatives demonstrated their frustration when dealing with staff within the provider's office. One person told us, "Office staff are not good at passing messages onto the carers. I cancelled over Easter as I was away but the carers still turned up." Another person told us, "The carers are very hard working and pushed but it's the lack of organisation from the office. It's also often an answerphone when I phone the office and they don't always get back to me. They don't let people know about staff changes. We get to know only through the carers. The organisation needs pulling up by the boot straps."

A relative told us, "It's very poor communication. Messages don't get through to the carers. I feel that it's a waste of time to ring them they don't take any notice." Another relative said, "Sometimes it's hard to get through to them in the office and in the evenings it can be hard to get through."

The care staff we spoke with told us they were able to contact the office when they needed and were confident that any information they passed to the office staff was dealt with. However, we found in some cases that this had not always been the case. The regional manager told us that more office staff had been recruited since the last inspection so they could deal with people's calls.

At the last inspection, we found that improvements were required to make sure that people's concerns and complaints were listened to and that the provider learnt from these. At this inspection we found that sufficient improvements had not been made.

All of the people we spoke with told us they knew how to complain. We received mixed views from people and relatives in relation to how well the service dealt with their concerns and complaints. Six of the 12 people and three of the five relatives we spoke with about complaints said they felt confident any

complaints or concerns would be listened to and dealt with. Some people said they had raised concerns and complaints in the past which had been dealt with to their satisfaction. One person told us, "They listened to me. They don't send a male carer anymore." A relative said, "We have no complaints. The manager was very nice and listened." A further relative said, "If I have a complaint I would ring the agency. They have listened in the past and got things sorted."

However, six people and two relatives told us that either their complaints had not been listened to or they would not feel confident to raise a concern. This was because they lacked confidence they would be listened to. One person told us, "I've made a complaint but they don't take any notice. I had one person visit, I think they were a quality officer. They said they would sort it but they haven't. I don't feel listened to at all. They don't answer my complaints or concerns." Another person said, "I've phoned them numerous times about the times when my regular carer is off and they say they will sort it but they haven't." A further person said, "I've never complained. The only people I'd complain about are those I'd have to speak to to make the complaint so that makes it difficult!"

A relative told us, "I sent a letter of complaint in January this year. I had no acknowledgement and so I phoned them in despair over the last month or so and they said they hadn't received it so I emailed it to [staff member]." They told us they had still not received a response although the complaint had been acknowledged. Another relative said, "I'd ring the office if I had a complaint although I'm not sure how much notice they would take. The main time I complained nothing happened."

Two people told us they had completed questionnaires where they had raised concerns but had not heard anything in relation to this feedback. One of these people added that they did not have confidence that they would be listened to if they raised a concern with the office. They said they did not feel the service was open and that they had tried to speak with the manager on occasions but been told they were not available with no attempt made to rectify their concerns. Two of the staff we spoke with provided this person with support. They told us they were aware that they had raised concerns with the office in the past.

We looked to see if any of these complaints that people said they had raised had been investigated and dealt with. We found that one person who had raised a complaint in July 2016 about the time of their care visits, had been visited by a quality officer to discuss this. The regional manager told us this complaint had been investigated but could not provide us with evidence of this as they said it had been archived. We saw that this person has raised the same concern to the provider during their survey in February 2017 and again to us during this inspection. Their complaint had therefore not been dealt with to their satisfaction. The complaints that one person and one relative said they had made to the office had not been documented on their record. Therefore these complaints had not been investigated. The regional manager told us that any complaint received either in writing or verbally, should have been recorded on their complaints system.

We looked at two written complaints that had been made to the service. We saw that a written reply had been sent to one person although this had been completed outside the provider's required time scale. We could not trace a reply to the other complaint. The regional manager assured us they had dealt with but could not find the reply they had sent to the person.

We have concluded that although the provider had ensured people know how to complain, the current system in place to ensure complaints are identified, received and investigated is not wholly effective. This has resulted in a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

Inadequate

Is the service well-led?

Our findings

At our last inspection in August 2016, we found that the provider's systems that were in place to monitor the quality and safety of the care provided were not always effective. This had resulted in a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014. Following this, the provider sent us an action plan to tell us what steps they would take to rectify this. They said they would make the necessary improvements by December 2016. However at this inspection we found that these had not been made. The provider had failed to drive the necessary improvement to ensure that people received good quality safe care.

Since our last inspection, the provider had monitored the quality of care provided by the service remotely from their head office. They had only conducted one audit visit of the service in April 2017. The regional manager said that since our last inspection, the provider had attempted to visit the office in November 2016 but had not been able to do so. The audit in April 2017 had identified a number of concerns. The regional manager told us that this had not improved on the audit the provider had conducted at the service in May 2016.

In their action plan that we received after the last inspection, the provider told us that they were recruiting more staff to meet people's needs and preferences. However, we found that this had not occurred at sufficient levels to meet all people's needs and preferences. The operations manager told us they did not currently have enough staff to do this, particularly over the weekends although steps were being taken to improve this.

In relation to monitoring the quality of care and risk, the provider told us in their action plan that the new role of quality officer had been introduced to specifically concentrate on these areas. We were assured at our last inspection that this would be their only function. This was because the provider knew that in the past, quality monitoring in some areas had been ineffective due to office staff having to cover care visits. However, we found that some quality monitoring officers were having to cover care visits due to a shortage of care staff. This again meant that some quality monitoring functions had not occurred as required by the provider. This included the auditing of people's medicine and communication records which would help identify if people had received their medicines and the care they required. The regional manager was not able to tell us when these had last been audited for some people.

Regular reviews of people's care needs had not taken place to ensure that their needs, risk assessments and records were accurate and reflected people's current needs. Only half the people using the service had received a review of their care within the last 12 months. The provider's requirement was that each person received an annual review. The provider had stated in their action plan after our last inspection that people's care records would be checked regularly for accuracy but this had not occurred. We found during this inspection that some information in people's care records and risk assessments was either inaccurate, incomplete or did not reflect their current needs. Therefore this system had been ineffective.

During our last inspection some eight months ago, the provider told us that a new electronic system had

been implemented that enabled the office staff to pro-actively monitor for missed or late calls. However at this inspection, the regional manager told us that only 57% of staff were currently using the system correctly. This meant that they could not monitor the system for these scenarios. They agreed that the current system in place to monitor for missed and late calls was not effective.

The provider had continued to fail to ensure people received continuity of care from a small number of staff. At our last inspection, the provider told us that 61% of people using the service were receiving care from a small number of staff which was below their target of 80%. We were told that a new member of staff had been employed to improve this situation. At this inspection, the provider had increased their target to 85% but their key performance indicator report for April 2017 stated that regular allocations were only occurring for 56% of people. The regional manager told us these figures were incorrect and that the actual situation had improved however, they were not able to provide us with any revised figures.

Some incidents and complaints had been reported to the office but had not been recorded on the person's electronic record and therefore not investigated. The operations manager told us that all information should be recorded on the person's electronic record where office staff had been involved in any aspect of their care. The regional manager confirmed there was no system in place to monitor and check that this was happening. This also demonstrated that accurate records had not been completed in respect of people's care. This was the case in respect of some people's medicine records that had not been updated correctly and some care records that held inaccurate information.

The manager told us that accidents and incidents had not been analysed until March 2017 but as all incidents were not being recorded, opportunities for learning were being missed.

This was a continued breach of regulation 17 of the Health and Social Care Act 20018 (Regulated Activities) 2014.

The regional manager was aware of most of the issues we found during this inspection. We saw that they had a comprehensive service improvement plan in place that they were currently working on to improve the quality and safety of the care provided to people. This has been in force since January 2017. The regional manager advised that they had needed to 'totally overhaul' the service to ascertain the level of care being provided before they could introduce measures and controls for improvement. Areas they had worked on included staff recruitment, training and competence. They were continuing to work on reviewing people's care needs, risks to their safety and introducing robust auditing functions. They admitted to us that their primary concern had been covering care visits but said this had improved. Therefore they were now able to drive improvement in other areas. They showed us some of the systems they now had in place to do this. At this inspection, it was too early for us to tell whether these will be effective.

There was no registered manager working at the service. The last registered manager de-registered with us in January 2017. The new manager started working at the service in December 2016. They had been employed as a regional manager to manage this service and some of the provider's other services. However, they told us they had decided to register as the manager only of this service and to work there permanently as they had come to the conclusion that the quality of care provided required improvement.

We received mixed views from people about whether the service was well led. Some people felt it was whilst others disagreed. One person told us, "I cannot fault them." A relative said, "I would absolutely recommend them." Another relative told us, "Yes I would recommend this agency, the staff are very nice." However, one person said, "The organisation is a shambles. There is a new management but they aren't up to date." Another person told us, "The office staff don't seem to know what they are doing. The reason Carewatch is

changing staff so often is the way the office staff treats the carers." A relative said, "No, I wouldn't recommend them."

We also received mixed views as to the openness of the culture of the service. Some people told us they felt listened to and could raise concerns. However, other said they were not listened to and were not confident any issues they raised would be dealt with.

All of the staff we spoke with felt supported in their role. They told us the regional manager and senior staff were approachable and open and they felt the current leadership at the service was good. They said that they had seen improvements in the quality of care being provided but were aware there were still some issues. Some staff told us how communication with the office staff was much better and that they understood was what happening in the service. They were aware of some of the actions the regional manager was taking to improve the quality of care people received. They all told us they enjoyed working for Carewatch (Dereham) and that their personal morale was good.

We were told at our last inspection that plans were in place to develop links with the community and to involve people who used the service and their relatives in doing this. This was to take the form of a regular 'forum'. However, this has not taken place although the new regional manager said they had plans to do this in the summer of 2017.

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 Care and treatment had not been planned or delivered to meet people's individual needs and preferences. Parts 1 and 3, b.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way. Risks to people's safety had not always been assessed or actions taken to mitigate those risks. Parts 1 and 2, a and b.

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Effective systems were not in place to identify, receive and recording complaints. Action was not always taken to rectify a complaint. Parts 1 and 2.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient staff employed to meet people's needs or preferences. Part 1.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Effective systems were not always in place to assess, monitor and improve the quality of care provided or to mitigate risks to the health, safety and welfare of service users. A contemporaneous record in respect of each service user had not been kept and people's feedback had not always been acted on. Parts 1 and 2, a, b, c, e and f.

The enforcement action we took:

We send the provider a warning notice and told them they had to be meeting this regulation by 30 June 2017.