Carewatch Care Services Limited

Carewatch (Central Norfolk)

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?	**Requires Improvement**

Summary of findings

Overall summary

This was an announced inspection that took place on 25 and 31 August 2016.

Carewatch (Central Norfolk) is a service that provides personal care to people in their own homes. At the time of the inspection, 286 people were receiving care from the service.

There was a registered manager working at 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.

At this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of this report.

There were not enough staff working at the service to cover all of the care visits that people required. Therefore, not all people had received individualised care that met their needs and preferences. Existing staff had been utilised to cover the shortfalls but there were not enough of them to do this. This meant that in some geographical areas, care staff had attended people's visits late or had arrived at inconsistent times. On occasions, some people had not been visited at all and therefore, had not received the care they required which placed them at risk.

Staff were kind and compassionate and treated people with dignity and respect. However, some people had been visited by a number of different staff they did not know well. This made it difficult for them to develop caring and trusting relationships with the staff.

There were a number of different ways that people could express their views about the service received and to make decisions about their care. Although people's complaints were investigated, not all people's feedback had been acted on. The necessary improvements had not been made in a timely manner to improve the quality of care that people received.

People's care needs and risks to their safety had been assessed. However, there was insufficient information within people's care records to guide staff on how to meet these needs and to reduce risks to their safety. As some staff were visiting people whose care they were not familiar with, sometimes at short notice, this lack of information increased the risk of people receiving poor care.

Staff asked people for their consent before providing them with care. However, not all staff knew how to act within the requirements of the Mental Capacity Act 2005 when providing care to people who were unable to consent to it themselves. Therefore, people's rights may not have always been respected.

There were systems in place to protect people from the risk of abuse and people received their medicines when they needed them. Where it was part of their care package, people received sufficient food and drink to meet their needs and they were supported to access healthcare services when needed.

The current systems in place to monitor the quality and safety of the service provided and to mitigate risk to people's safety were not all effective. The provider was aware that the quality of service they were providing to people needed to be improved. Plans were in place to implement these improvements.

We have made a recommendation regarding following the principles of the Mental Capacity Act 2005 when making best interest decisions on behalf of people.

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 provide people with the care they required.

Risks to people's safety had been assessed but the actions that needed to be taken by the care staff to reduce this risk were not always clear.

The provider had systems in place to reduce the risk of people experiencing abuse.

People received their medicines when they needed them.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff had received training on how to provide people with care but their competence to do so safely and effectively had not always been assessed in line with the provider's requirements.

Not all staff knew how to apply the principles of the Mental Capacity Act 2005 to their care practice. Therefore there was a risk that people's rights were not being protected.

Where it was part of the care package, the staff supported people to eat and drink sufficient amounts to meet their needs. They also supported people with their healthcare needs.

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 people with their care which made it difficult for them to develop caring and trusting relationships with them.

Arrangements were in place to support people to express their views about their care and to be actively involved in making decisions.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs had been assessed but there was not always clear guidance in place to tell care staff how to provide this care to meet people's individual needs.

The care was not always provided to meet people's individual needs and preferences.

People knew how to complain. When a complaint had been received it had been investigated by the provider. However, the provider did not always learn from people's complaints.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The systems in place to monitor the quality and safety of care provided were not all effective.

There was a registered manager in place but they also managed another location and were the provider's regional manager. Therefore, consistent leadership was not always present at the service.

Carewatch (Central Norfolk)

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 25 and 31 August 2016 and was announced. The provider was given 48 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 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. Their area of expertise was with regards to care being provided for older people within their own homes.

Before the inspection, we requested that the provider complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This was received from the provider. We also reviewed other information that we held about the service. We had requested feedback before the inspection from the local authority safeguarding and quality assurance teams.

During this inspection, we spoke with 11 people who used the service and six relatives of people who received care from Carewatch (Central Norfolk). We also sent 50 people a questionnaire about the care they received. Twenty one people completed this questionnaire. We also spoke with eight staff and the registered manager.

We looked at the care plans and risk assessments of 13 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. Not all the records we wanted to look at in relation to people's care were available to us. This was because the service had recently moved to a new location following a flood. Some records were waiting to be unpacked and filed whilst others were being repaired following the flood. We did

however, manage to look at five people's medicine administration charts and six people's communication logs. These are records that staff complete in people's homes following their visit.

Requires Improvement

Is the service safe?

Our findings

Before the inspection, we had received concerns that some care visits had been missed. This had resulted in some people not receiving the care they needed. We found that there were not always sufficient numbers of care staff to provide people with safe care and to meet their needs.

Eleven of the 17 people and relatives we spoke with on the telephone told us they did not feel that there were enough care staff available to provide them or their family member with the care they required. Five of the 11 people we spoke with on the telephone told us they had experienced missed visits. One person told us, "As recently as last Thursday we had someone not turn up for a call." They went on to tell us they were able to ask a family member to help them instead but were concerned that care staff had not attended. Another person said, "They [the staff] did not turn up last Tuesday when they were supposed to."

Three of the six relatives also said that care staff had not always turned up when they were scheduled to. One relative told us, "One Sunday no one turned up. On two occasions they have not turned up." They told us how they had waited for the care staff but then decided to help their family member up themselves which they had found difficult. This had also meant that their family member had not been able to get up at a time of their choosing. Another relative said, "One night they did not turn up for the evening call. I had to help [family member] to bed."

Fifteen of the 21 people surveyed told us the care staff stayed for the correct amount of time when providing people with care but six said they did not. We received mixed views from the people and relatives we telephoned. One person told us, "They always stay the full time, they take their time with me. They have a chat and before they leave they say, 'anything else I can do', but these are my old carers." Another said, "I don't really know how long she stays but she makes sure I am alright." However, one person said, "They are supposed to stay half an hour but they often stay maybe for ten minutes."

Another person told us, "The night call is supposed to take 15 minutes but they sometimes only stay for three. They are supposed to be ten minute visits the other ones but they stay less than five and spend more time writing in the book than doing anything else." A relative said, "One day [family member] spent a few too minutes on the toilet so she cancelled his shower." Another relative said, "Some staff stay the full time but some do it in half the time and then just go but I don't like to complain." Two of the six people's communication records we checked confirmed that care staff did not always stay for the length of time they were supposed to.

Another person told us how two care staff were required to help them with their care. They went on to describe a time when only one care staff member attended the call. They said, "Only one carer came and so my sister in law came and helped." A relative told us of a similar experience. They explained how their family member, who was receiving end of life care, required two care staff to help them but that 'often only one arrived.' They added, "There was always some excuse like off sick or something so sometimes I had to help." Another relative said, "They are so short staffed. Weekends are awful, different carers, not on time I dread them."

We looked at the care records of two people where the provider had assessed that for person's and care staff's safety, two staff were required to assist them to move. We found that on occasions, only one care staff member had assisted. This was potentially unsafe and had exposed these people and the staff member involved to the risk of injury. We spoke to a member of care staff who regularly saw one of these people. They confirmed they had regularly had to support the person on their own.

The care staff we spoke with told us they were usually able to visit the people they regularly supported and that they had not missed visits. However, they all said they had been regularly asked to attend extra visits on top of their normal workload. Some told us that this was not a problem for them as they had the capacity to take on extra work. However, other care staff said that this was having an impact on their ability to spend the time with people they were supposed to. They also said that they were not always taking breaks due to the amount of work they had to complete. During our time in the office, we regularly heard the office staff contacting care staff asking them to cover visits for that week with some care staff being asked to cover visits on that day.

We spoke with the registered manager about the missed visits. They told us that the provider had recently changed the electronic system that was used to monitor when care staff had attended care visits. During this switch over, an error had been made at the provider's head office which had resulted in the care staff's schedule of visits being incorrect. Subsequently a number of care visits had been missed one weekend in July 2016. The registered manager explained that once this had been identified they had tried to make contact with all of the people affected to make sure they were safe.

However, a number of the concerns we received about missed visits were in relation to visits due in June and August 2016. We asked the registered manager to look into three of these visits that people had told us had been missed. One visit was accounted for on the computer system but the others were not.

The registered manager told us they had experienced some difficulty in recruiting care staff to rural areas covered by the service and acknowledged that this was currently an issue. In response to this, the provider had employed a recruitment officer who was responsible for recruiting more staff. The registered manager told us that the introduction of this new role had improved recruitment to the service and that they were on target to recruit the number of care staff needed by the middle of September 2016.

The service was also experiencing difficulty in covering care staff absence due to sickness and unauthorised absence. Existing care staff, the staff working in the office and a small number of bank care staff were utilised to cover such absence. However, some of these staff were also absent so could not cover care visits. On the second day of our inspection, some staff from the registered manager's other service had been brought in to cover for the absent office staff at Carewatch (Central Norfolk) so that it could run effectively. The registered manager told us they had also recently been covering care visits. This meant that the contingency plans for covering unplanned staff absence were not always sufficient to cover the visits required.

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

Risks to people's safety had been identified. These included risks in relation to supporting people to move, taking medicines, falls and in the event of a fire. However, although the care staff we spoke with knew how to reduce the risk of people experiencing harm, the information within the risk assessments was not sufficient to give care staff clear guidance on how to do this effectively. This was important as the service had recently recruited a number of new care staff who could be reliant on this information. For example, four people whose care we looked at had been identified as being at high risk of slips or falls. The actions for care staff to take to reduce this risk had either not been documented or was very brief such as, 'allow plenty

of time to mobilise' or 'make sure got walking stick.' For two people who had been identified as being at high risk in the event of a fire, no actions had been documented.

The registered manager told us they had identified that the assessment of risk to people's safety required improvement. We saw this had been documented on their 'improvement plan' for the service.

All of the people we spoke with told us they felt safe when the care staff provided them with care in their own home. One person told us, "The carers are good. They are careful and it is good to see them. I look forward to it." Another person said, "Oh yes, I always feel safe when they are here." All of the people who answered our questionnaire also told us they felt safe when the care staff were in their homes.

Systems were in place to protect people from the risk of abuse. All of the care staff we spoke with and the registered manager knew how to protect people from the risk of abuse and told us they received regular training on the subject. The records we looked at confirmed this. They understood the different types of abuse that could occur and how to report any concerns. The registered manager was also aware of their responsibilities to report and investigate any alleged abuse. We saw that where there were concerns about people's safety that the staff had reported it to the office and action had been taken to monitor the situation.

Three of the four care staff files we checked contained the required checks before they started working for the provider. This included an appropriate Disclosure and Barring Service (DBS) check to make sure that they were suitable to work in care, a full record of their employment history and two references documented on their files. The employment history of one care staff member had not been fully explored and we brought this to the registered manager's attention. They agreed to look into this. Care staff confirmed to us that these checks were in place before they started working for the service.

The care staff were responsible for giving five of the people we spoke with their medicines. Four of the people we spoke with about this told us they received their medicines when they needed them. All of the care 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. The care staff files we looked at confirmed this.

We checked five people's medicines administration records to see if they confirmed that people had received their medicines as intended by the person who had prescribed them. Four records confirmed this but one did not have a signature against some medicines. We brought this to the registered manager's attention who cross referenced it against the notes made by the care staff during their visit. These confirmed that the person had been given their medicines but that the medicine record had not been updated correctly. The registered manager took immediate action to remind care staff of the importance of updating these records. From the evidence we saw, we were satisfied that people received their medicines when they needed them.

Requires Improvement

Is the service effective?

Our findings

Eighteen of the 21 people we surveyed told us they felt that staff had sufficient skills and knowledge to provide them with the care they required. However, 14 of the people and relatives we spoke with over the telephone about this subject, expressed some level of concern. They told us they were happy with their regular care staff but felt that staff they were not familiar with had not received sufficient training.

One person told us, "I had a problem with an enema once and they cleaned me up but they left the bed in a state for a week and I complained, you'd think they would know better." Another person said, "One [staff member] came the other night and said 'I don't know what to do' so I just showed her myself." Another person said they were not confident that the care staff were correctly trained.

One relative said, "Our regular carers are good but the new ones not so much. I end up doing half the job because I do all the preparation." Another relative told us, "The juniors are just not used to it. I tell them what they have to do, they are very young."

All of the care staff we spoke with told us they felt they had received enough training to provide people with effective care and that they felt supported in their roles. The registered manager showed us the training programme for the year and we saw that the majority of care staff training was up to date. Training had been received in subjects such as dementia awareness, moving and handling, safeguarding, health and safety, and infection prevention. A regional training manager was employed by the provider who was responsible for staff training.

We spoke to two new care staff about their induction training which they told us had been good. This had consisted of a week of class room based learning, in a number of different areas. This included a variety of learning methods and "Group discussions." They also had practical hands on training with various pieces of equipment so they could support people to move safely. After this, they had been paired up with a more experienced member of care staff and spent time shadowing them until they were confident to provide care on their own. The new care staff confirmed to us they had been regularly observed for a three month period to ensure they were competent to perform their role.

The registered manager told us that the care staff's competency to perform their role safely and effectively was required to be checked on a regular basis. This involved them being observed whilst they performed care. However, they said that they were behind with this. At the time of our inspection, 28% had received an observation and 49% supervision as was required by the provider. In view of people's feedback in relation to staff competence and the fact that 72% of staff had not had their competency assessed in line with the provider's requirements, we have concluded that improvements are required within this area.

Of the three people and relatives we spoke with about consent, all of them told us that the care staff asked for consent before care was provided. One person said, "They always say what we need to do and then I agree. They are good my carers."

The registered manager and the staff we spoke with told us that some people they provided support to lacked capacity to make their own decisions. This meant they had to adhere to the principles of the Mental Capacity Act 2005 (MCA) in their care practice. The 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. We checked whether the service was working within the principles of the MCA.

The care staff we spoke with demonstrated a mixture of knowledge regarding the MCA. Some staff understood how this legislation affected their care practice. They were aware that any actions they took for people who were unable to consent to them had to be performed in their best interests. However, other care staff were not clear about this although all them told us they always offered people choice. For example, the care staff said they helped people to make a decision about what to eat by showing them the food on offer.

There was information in some of the care records we looked at regarding what decisions people could and could not make themselves. Guidance was also available to staff regarding what they needed to do to support people to make decisions such as what clothes to wear. However, this had not been consistently recorded within all people's care records with this section often not having been completed. We have therefore concluded that improvements are required to care staff knowledge and the records kept relating to the MCA to ensure that people's rights are always respected.

People told us that where it was part of their care package, that care staff prepared their food and drinks to their liking. One person told us, "They ask what I like and then I choose and they cook it." They did however add that once in the past no one had turned up one lunchtime which had meant they missed their lunch. Another person said, "They cook my meal in the microwave. It is hot and sorted."

The care staff we spoke with told us they were aware of the importance of supporting people to eat and drink sufficient amounts for their needs. One staff member said they always made sure they left people with a drink and monitored how much they had drunk between visits. They all told us that if they had any concerns, that these needed to be recorded and reported to the main office. The care staff also demonstrated to us that they knew people's individual food likes and dislikes and they were clear about people's various dietary requirements. These were also noted within people's care records.

Most of the people we spoke with told us they arranged their own healthcare. However, they said they were confident that the care staff would assist them with this if required. All of the care staff we spoke with demonstrated to us they had a good understanding of the different types of healthcare professionals who could be contacted to help people maintain good health. These included an optician, district nurse, GP or occupational therapist. We saw evidence in some people's care records that care staff had contacted a GP when they had been concerned about the person's health.

We recommend that the service considers current guidance in relation to applying the principles of the MCA 2005 before making decisions on behalf of people in their best interests.

Requires Improvement

Is the service caring?

Our findings

Prior to our inspection we had received some concerns that a number of different care staff were visiting to provide people with care. This impacted on their ability to get to know people and build caring relationships with them. During our inspection, we found this to be the case.

Eighteen of 21 the people we surveyed told us they received care from the same care staff. However, nine of the 17 people and relatives we spoke with over the telephone told us this was not the case. They added that they often did not know which care staff were coming to provide them with care. Eight people we surveyed said they were not introduced to new care staff and this was echoed by the people and relatives we spoke with over the telephone.

The registered manager told us in their PIR that people were sent a copy of their care schedule each week so they knew which staff to expect. However, some people and relatives said this often changed without them being told or that the schedule said that care staff had not yet been allocated to the call. One person said, "Even if they do send us a list it isn't much use if it has lots of 'unallocated' against it, then it isn't reliable." Another person said, "I never know who is coming. I have so many different people. I know some of them but there are so many."

All of the people we surveyed said the staff treated them with dignity and respect and this was echoed by most of the people and relatives we spoke with over the telephone. However, some told us having staff they did not know concerned them, particularly when receiving assistance with personal care which they did not feel was dignified. One person told us, "Well they try to be good but I do find it embarrassing to have a really young slip of a thing helping me with my wash. It is not very dignified." A relative told us, "Last week we had seven different carers. The last three nights we have had new ones. They come in and don't even say their names. They are going to be intimate with [family member] and I don't even know who they are."

The care staff we spoke with told us they were able to provide consistent care to some people but added that they had frequently been asked to see different people that were not usually on their care round. They also told us they were not always introduced to these people before being asked to provide them with care. We checked some people's records to ascertain how many carers they were seeing each week. We found that some people saw the same carers each week. However, others saw several different staff members for their visits.

We spoke with the registered manager about this. They told us they had identified this issue and said that at the time of the inspection, 61% of people using the service were receiving care from a small number of care staff. This was below their target of 80%. Therefore the provider had employed an extra member of staff to review the care visits that people were receiving. This aim of this was to try to reduce the number of different staff people saw during the week. Improvements are therefore required in this area so people can develop caring and trusting relationships with care staff.

All of the people we surveyed told us that the care staff were kind and caring and most of the people and

relatives we spoke with on the telephone agreed with this. One person told us, "I'm always very pleased to see them, they are very good indeed." Another person said, "I would not be without my carer. She is lovely." A relative told us, "We have some really nice carers and they are very good." Another relative said, "Most of the carers are friendly and willing."

The care staff we spoke with demonstrated they had a caring approach when supporting people. One staff member told us how they treated people how they would want their own family member to be treated. They were all clear about the importance of respecting people's privacy whilst providing them with care and gave us appropriate examples such as closing curtains or covering people when giving personal care.

The majority of people we surveyed prior to our inspection told us they were supported by the service to express their views and make decisions about their own care. People and their relatives we spoke with on the telephone told us they were satisfied they were able to make choices about their own care. The records we saw showed that the person and their relative if required, had been asked how they wanted the care to be delivered during the initial assessment of their individual needs when they started to use the service. All of the people involved had signed their care record to agree to this care.

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 took place four times each year. These were held either face to face or over the telephone. However most of the people we spoke with told us they could not recall having a review of their care. One person said, "The last review I had was about a year ago, previously I had not had a review for four years." A relative told us, "I can't remember ever having a review of our care, no one has been out for over a year." Another relative said, "I have to phone the office with changes, they haven't been out to do a recent assessment."

The records we looked at showed that 12 of the 13 people whose care we looked at had received some form of review within the last 12 months. The registered manager told us the service had not completed these reviews as frequently as they wanted to but that improvements were being made to this.

Requires Improvement

Is the service responsive?

Our findings

Before the inspection, we had received concerns that care staff were often arriving late to provide people with care and/or arrived at inconsistent times that did not suit people's individual needs. We found that people did not receive personalised care that was responsive to their needs.

Eleven of the 21 people we surveyed and seven of the seventeen people and relatives we spoke with told us care staff were sometimes late or arrived at different times that did not meet their individual preference.

One person told us, "I told them I wanted a call about 5.30pm because I like fresh food cooked and on the table at 6pm or around that time. I complained because they send them at 3pm or 4pm but it's for my evening supper. They just say I am down as flexible." A relative said, "We like our call at 10pm at night so they [family member] can be helped to bed. Sometimes they don't turn up until 11.30pm so I have to do it myself. One night the carer turned up at 7.45pm which isn't what we wanted." Another relative said, "We recently requested an 8.15am call and they turned up at 10.30am." The relative told us how they had to help their family member get up. A further relative said, "We have a 1pm call but they sometimes come early which interrupts my meal."

Of the six records we were able to check we found that four people received care at consistent times throughout the day but two others did not. One person's evening call varied from 6.25pm to 9.05pm. Another person's morning call varied from 8.40am to 10.52am.

We asked people if their preferences in relation to the times staff provided them with care and the gender of the carer they preferred had been sought when they started using the service. None of the people or relatives we spoke with said they had been asked this. One person told us, "They never asked me that." A relative said, "We don't have choices of times because even if we do ask you don't get it. They just come when they want anytime between 7am and 10am. We have never been asked whether we want male or female carers."

The care records we checked did not demonstrate that people's preferences in relation to the time they wanted to be cared for had been assessed. The gender of carer they wanted was also not documented within their care record although the care staff told us that this was respected. The registered manager told us it was difficult for them to provide people with set visit times but that they were trying to make improvements within this area.

People's care needs had been assessed before they started using the service. This assessment was comprehensive and covered areas such as people's medical history, their mobility, communication, expected outcomes and nutrition. However, some care records lacked detail regarding what support care staff needed to give to meet these needs. This was a risk due to staff providing care to people they were not familiar with. For example, one person had a stoma bag and the instructions for the care staff were to check it regularly. When we asked the registered manager what this meant they said the care staff were to check for redness around the stoma sight, that it was not full and that the person was comfortable. None of this

critical information was documented. Another person had diabetes but there was no information within the care record to guide staff on how to support the person with this condition.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2014.

We asked care staff whether the care records contained enough information to enable them to provide people with the care they needed, particularly if they were asked to provide them with care at short notice. We received mixed views.

Some care staff told us they thought there was enough information in the care records. They said that information was obtained about a person they were not familiar with either from the office staff or care staff who were familiar with the person's care needs. However, other care staff said they did not feel that all care records contained sufficient information about the person to enable them to provide them with effective care. Due to this, some told us they had to spend time reading the person's notes in their home to try to ascertain what they needed to do. Others said they had to ask the person or relative what care needed to be given. The registered manager told us they had recognised this issue and that plans were in place to improve the content of people's care records.

Everyone we surveyed and spoke with over the telephone knew how to contact the office if they needed to. However, some of the people and relatives told us they had experienced difficulty in speaking to someone in the office or had not been told if the carer was going to be late. One person told us, "They never phone if someone is late. If I phone the office they say, 'oh isn't she there yet' and then when the carer does turn up she says it wasn't on her list." Another person said, "I tried to contact the office but no-one answered. I left a message but no-one phoned back. No one answers out of hours." A relative echoed this, they told us, "When no-one turned up I rang the office. I left a message but never heard anything."

The care staff we spoke with told us there was an out of hours service which people could contact and which they also used. They said that they now had no issues contacting the office when they needed to but that this had been an issue in the past. This was because the staff member doing the out of hours service had often been covering care visits so they had not always been available when needed. The registered manager told us that during the recent flooding at their previous location, the available phone lines had been reduced from eight to one mobile phone. They said this had now improved since moving into the new location with more phone lines available for people to use.

Some people and relatives said they did not think the communication was very good in the office. One person said, "The office is shockingly disorganised. Cancellations are frequently not passed on to the carers so they arrive when cancelled and vice versa. These carers work very hard, cheerfully no matter what pressure they are under and I feel strongly that they deserve better support from the office." Another person said, "I phoned three times to tell them that I needed to cancel and change visits as we were having a weekend away. They hadn't done it right. They are not efficient." A relative said, "I don't even ask them to change things now, they are so unreliable and I don't have confidence to rely on them."

We spoke with the registered manager about this feedback. They acknowledged that there had been issues within the office, particularly during the move to a new office after the flooding of their old office. They were confident however, that the service would improve in the near future.

All of the people we surveyed and the majority of people and relatives we telephoned knew how to complain to the service. People were given this information when they started to use the service.

Fourteen of the people we surveyed said they believed that their complaints would be responded to well but seven did not agree with this. This feedback was reflected during our telephone conversations with people and relatives. Most of the people and relatives we spoke with told us they had had cause to complain whilst using the service. Some told us that their complaints had been responded to effectively and to their satisfaction. One person said, "I have complained. One of the carers was writing down things that she didn't do so I told the office. We haven't had her again." Another person told us how they had complained about a staff member and that they had asked not to have them again which had been respected.

However, other people and relatives told us that their complaint had not been listened to and that nothing had changed. One person said, "I've complained before. I told them I don't want them coming late for tea but I don't want them at 4pm either. But they don't take any notice." A relative said, "I told them I wanted to be notified if a call is late. I am fed up with it. I complained but they still don't do it, they just say they forget. Not much use complaining."

One person's records we looked at showed they had fedback in February 2016 that they were unhappy about the inconsistent times of their care visits. We found that this had not improved and was still continuing in June 2016.

The provider logged all complaints that were received onto a central computer system. The registered manager told us on their PIR they completed on 8 June 2016, that the service had received 11 complaints within the last 12 months. We saw that the registered manager had followed the provider's complaints procedure and had completed an investigation in response to each complaint that had been received.

The registered manager had analysed the complaints received to ascertain whether there were any themes. They had discovered that the lateness of people's visits was a theme. They told us on their PIR that they had reviewed the communication process between the staff and people using the service to improve this. However, we found that this was still an issue. Therefore, improvements are required to make sure that the provider listens and learns from people's experiences, concerns and complaints.

Requires Improvement

Is the service well-led?

Our findings

The systems in place to assess and monitor the quality and safety of the care provided were not always effective. Actions had not always been taken in a timely way to mitigate the risks to people's safety. This had resulted in some people experiencing poor quality care.

The current systems in place to make sure there were enough staff available to provide people with safe, good quality care were not effective. Although the provider knew how many staff they required to complete all care visits, they had not made sure they had sufficient staff in all geographical areas they covered to enable them to do this. The contingency plans in place to cover unplanned staff absence were not sufficient.

The provider had not ensured that there were sufficient staff employed to enable the quality and safety of the service to be monitored effectively. The registered manager told us that staff in the office had been responsible for this. However, historically these staff had been used to cover the shortfall in care staff and were therefore, often working outside of the office. The registered manager said this had impacted on the team's ability to monitor and improve the quality of care provided.

The registered manager told us that the provider required 10% of all people's medicine administration records (MAR) and communication records to be audited each month. This was so they could identify whether people had received the care they needed. They said they were confident that this had been achieved. We checked five people's MAR and six people's communication logs to ascertain when they were last audited and whether the audits were effective. One person's MAR had been audited in August 2016, but two had not been audited since March 2016. We were unable to ascertain when the other two had been last audited as not all of the records were available to us. This was the same with the communication logs.

We therefore asked the registered manager to confirm when people's records had last been audited but they were unable to tell us. This was because there was no system in place to identify what documents had been audited when and for whom. Therefore the registered manager could not make sure that each person's records were audited on a regular basis so that any issues could be identified and dealt with quickly. There was also no overview of actions that had been taken to help with the identification of themes to enable the provider to learn from any errors that had been made.

The current systems in place had not identified that the required number of staff were not always attending people's care visits. Therefore, risks to people's safety were not being mitigated effectively.

We saw that some people's views about their care had been obtained via telephone interviews. Where the response was a negative one, we could not see that action had been taken to address this with the person. The registered manager told us that action was always taken but no evidence of this could be found on the computer system for the two cases we looked at.

There was no overall system in place to analyse any negative comments people made about the care they received to help drive improvement. Also in May 2016, the provider had conducted a survey that had

identified that people were concerned that they did not know which carer would be attending their call. We found this still to be the case some three months later and therefore, any actions taken had been ineffective to improve this.

A new system had recently been implemented within the service called Total Mobile Solutions (TMS). The intention of this system was to improve the registered manager's ability to monitor for missed and late visits. When this occurred, an alert was sent to the office so they could respond in a timely manner. A weekly report was also produced so the registered manager could monitor this. However, the registered manager told us that some initial problems were being experienced with this system which was making it difficult for them to effectively monitor for missed or late visits. This was because the system was dependant on the care staff member having a mobile signal within the area they were delivering care. If no mobile signal was available then the system would not receive any information.

This was also having an impact on updating the care staff's schedules with any changes in care visits. Where no mobile signal was available, the visits were not being updated. This meant there was a risk that visits could be missed. The registered manager told us the issues in relation to the TMS system had been reported to the provider who was investigating.

The registered manager had to send a report to the provider each month regarding the performance of the service. They acknowledged that they were behind in a number of areas. As at August 2016, it was reported that 51% of people had received a care review in line with the provider's requirements and 61% of people had received care from regular care staff. A total of 28% of staff had received an assessment of their competency and 49% had received the required amount of supervision. The registered manager told us that the target was 80% for each of these areas.

The provider had not ensured that there was effective leadership at the service at all times. Although there was a manager registered at the service they also managed another of the provider's locations which was approximately ten miles away and were working as a regional manager. Recently they had also had to cover care visits due to the shortage in staff availability. This meant that there was not always effective leadership present within the office to manage and oversee the day to day running of the service.

There was no system in place to analyse accidents and incidents for themes to enable the service to learn from them. The registered manager told us they knew of all incidents that had occurred and were confident that they would be able to identify any patterns. However, due to the size of the service and the registered manager's availability there was a risk that these opportunities could be missed.

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

The provider was aware of the issues affecting the quality of the care that people received and had plans to improve this. In response to the lack of staff, they had recruited a recruitment officer with the specific aim to recruit more staff to the service in areas they were experiencing problems. They had increased the pay rates to attract new staff and had offered bonuses and incentives to existing staff to cover extra care visits. The registered manager told us that a new deputy manager who was due to start working at the service imminently, had been recruited to support them with the running of the service.

A recent audit conducted by the provider had also identified that the information held within people's care records needed improving and a new staff member had been employed to try to improve the continuity of care people received.

The provider had also recently introduced a new role of Quality Officer. Three had been recruited at Carewatch (Central Norfolk) and they were currently completing their training. The registered manager told us they would be responsible for monitoring all aspects of the quality of the care provided. This was so that the provider could identify issues in a timely way and drive improvement within the service. The registered manager was confident that the quality of service that people received would improve once these roles had been embedded and confirmed that these staff would not be used to cover unallocated care visits.

The training of staff was monitored effectively. Each month details of the training staff had completed was sent to the provider's training manager. Any shortfalls in their training were then addressed.

Most of the staff we spoke with told us they felt the service was well led and that the senior staff were approachable. They were confident that any concerns they raised would be dealt with effectively. However, only twenty of the 38 people and relatives we surveyed and telephoned were fully happy with the service they received from Carewatch (Central Norfolk). Twenty two of the 38 said they would recommend the service to others. Ten of the people and relatives we spoke with on the telephone told us they did not feel that the service was well-led. Most of them also told us they did not know who the registered manager was.

Most of the staff told us they felt valued by the senior staff at Carewatch (Central Norfolk). The registered manager had introduced an "Employee of the month award." Staff who had received positive feedback from people who used the service or from colleagues would receive a gift, often flowers, awarded by the registered manager at the staff meeting.

The registered manager wanted to develop links with the community, and involve people who used the service and their relatives further. As a result of this a "Forum" has been planned for December which was to include care and office staff. Local health professionals had also been invited. These had been held in the past and had been found to be an effective way of gathering feedback from people about the care received. None had recently taken place due to the flooding of the previous office.

The service was also improving the information they gave to people and relatives about other professionals they could access if needed to improve the safety of their home or their quality of life.

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 The care and treatment of service users had not been designed with a view to achieving their preferences and ensuring their needs were met. Not all people's preferences in how they wanted to be cared for had been identified. Regulation 9 (1), (3) (a) and (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The systems and processes in place were not operated effectively to enable the quality and safety of the service provided to be assessed, monitored and improved and to mitigate risks to people's safety. Feedback from people about the quality of care they received had not always been acted on. Regulation 17 (1), (2) (a) (b) and (e).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing There were not sufficient numbers of suitably qualified, competent and experienced staff working at the service to meet people's needs and to provide them with safe care. Regulation 18 (1).