Corinium Care Limited

Corinium Care Limited

Inspection report

George Street
Nailsworth
Stroud
Gloucestershire
GL6 0AG

Tel: 01453839290
Website: www.coriniumcare.com

Date of inspection visit:
20 February 2019
21 February 2019
22 February 2019
05 March 2019
11 March 2019

Date of publication:
20 June 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
Corinium Care Ltd provides live-in support to people in their own homes. At the time of the inspection 176 people across England and Wales received support from the service to meet their personal care needs.

The Care Quality Commission (CQC) only regulates the regulated activity of personal care; this inspection report only relates to the provision of personal care.

People's experience of using this service:
•□The majority of people and their representatives (the agency's clients) told us they were satisfied with the care provided to them by their live-in carers. These people often had the same live-in carers and well-established relationships with them.
•□These people spoke positively about their care provided by the live-in carers. Comments included: "It's like having another daughter, we get on so well, that's so important. I'm hugely lucky", "[Name of carer] is excellent" and one person's representative described the care saying, "It's of the highest quality and standard."
•□Prior to and during the inspection we received less positive feedback from some people and their representatives. They had experienced more changes in live-in carers than they had initially expected or wanted, had experienced an unsatisfactory client and live-in carer match and had experienced a lack of standard in the quality of the live-in carer provided.
•□A common area of dissatisfaction was the level of communication people experienced from the agency's office, particularly at times when a new or replacement live-in carer was to be organised.
•□In 2018 there had been several changes in managers responsible for managing the agency's office and the provision of care, as well as changes in care managers and office staff. Changes in office staff had impacted on the agency's ability to always communicate with the 'client' in a way which best suited them.
•□Care managers assessed people's needs and were key in helping the office staff understand the type of carer needed. They reviewed people's support plans, communicated with the 'clients' and were there to resolve any communication or care issues. One person's representative had experienced several changes in care manager, they said, "I can never speak to the same person twice."
•□Prior to our inspection senior managers had been aware of where the service needed to improve and during the inspection they openly discussed with us, and shared with us, their action plans to address this.
•□We found many improvement actions had already started but which needed now to be sustained. These included improved guidance for staff working in the office ('bookings' and 'client contact' teams), changes to the recruitment and induction process for live-in carers and better arrangements for ensuring 'client' support calls were made where required.
•□At the time of the inspection a regional manager was managing the office and supporting the organisation of all care support. The office teams were more settled and working well together; benefiting from the improved management support.
•□We found improvement actions had also started, in relation to ensuring accident and incident records,

mental capacity assessments and best interests meeting records and investigation records were completed and maintained. Also, to make sure consent, when obtained, was always recorded. Further training and discussion around investigation recording and accident and incident reporting and recording was to take place with care managers.
•□These areas of improvement needed to be embedded in practice and then sustained to evidence that the provider's actions had been effective in bringing about the required improvements for people.

Rating at last inspection:
Service rating was Good; inspection report published on 15 January 2018.

Why we inspected:
The most recent inspection, started on 20 February 2019, was brought forward due to information of concern received by CQC.

Follow up:
We will continue to monitor intelligence we receive about the service and to liaise with the provider about the improvements they are making to their service. We will return to inspect the service as per our inspection programme. If any concerning information is received we may inspect sooner.

We will also ask the provider to send us an improvement plan showing the action they are going to take to improve the key question; 'Is the service Well-led?' to at least Good.

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

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe. Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective. Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring. Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive. Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was not always well-led. Details are in our Well-Led findings below.	**Requires Improvement**

Corinium Care Limited

Detailed findings

Background to this inspection

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

The planned inspection for the service was brought forward because information of concern had been shared with the Care Quality Commission (CQC). This information had predominantly included concerns about poor matches between 'client' and live-in carer and the poor level of communication people's representatives experienced from the agency's office. In some cases, there had been concerns relating to the quality of care provided. These concerns had been investigated by the agency and some had been substantiated and subsequent action taken.

This inspection examined the systems and processes in place which were designed to ensure people received a safe, effective, caring and responsive service. It also examined the agency's management arrangements and the effectiveness of their quality monitoring systems.

Inspection team:
The inspection was predominantly completed by one inspector who was joined by a second inspector on 5 March 2019.

Service and service type: Corinium Care Ltd is a domiciliary care agency (DCA) which only provides live-in care staff to people in their own homes.

The service is required to have a registered manager. At the time of the inspection there was not a registered manager. The previous registered manager had left in September 2018. A registered manager and the provider are both legally responsible for how the service is run and for the quality and safety of the care provided. A regional manager was providing management support and planned to apply to be the registered manager until a permanent candidate could be identified.

Notice of inspection:
We gave the service three days' notice of the inspection site visit because we wanted to ensure that managers responsible for supporting the service would be available.

Inspection site visit activity started on 20 February 2019 and ended on 11 March 2019. We visited the office location on 20, 21 and 22 February 2019 when we spoke with managers, office staff and reviewed care records, policies and procedures and other service management records. We visited the office site on 5 March 2019 to meet with care staff and visited again on the 11 March 2019 to meet representatives of the provider.

What we did:
Before inspection: We reviewed all the information we held about the service which included, information of concern and statutory notifications. Statutory notifications are when the provider notifies CQC about events which they must legally make CQC aware of. A Provider Information Return, as part of the Provider Information Collection, had not been received prior to this inspection as the inspection was brought forward. Providers are required to send us key information about their service, what they do well, and improvements they plan to make. This information helps support our inspections.

During inspection: We spoke with two people and their live-in carers in their homes. We spoke with one care manager who was carrying out a review visit with one of these people. We also received feedback, by email or telephone call, from two further people who used the service and 15 representatives of people. At the agency's office we spoke with eight live-in carers, one other care manager, members of the 'bookings' and 'client contact' teams, the training manager and the communications, marketing and recruitment manager. We spoke with the regional manager, the operations director (Nominated Individual for the provider) and the chief operations officer.

We reviewed the care records of seven people. These included the initial assessment of need, risk assessments and support plans. We reviewed two staff recruitment files. We also reviewed a selection of quality monitoring records and other management records which included: audits, management reports, action plans, complaints records, minutes of staff and management meetings, a recruitment analysis report, care staffs' training records and the provider's safeguarding policy.

Good

Is the service safe?

Our findings

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

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse.
•□All agency staff received training on this subject. They knew how to recognise potential abuse, what action to take to protect people and who to report their concerns to.
•□Staff felt confident enough to report poor practice and confident that the agency's managers would act accordingly to protect people.
•□Managers liaised with relevant local authority safeguarding teams and shared appropriate information to protect people from abuse.

Assessing risk, safety monitoring and management; Preventing and controlling infection.
•□Care managers completed risk assessments which identified the risks to people's health and wellbeing and what action must be taken to reduce these risks.
•□People's support plans gave staff guidance on how to manage identified risks. In some cases, live-in carers worked collaboratively with care managers, people's representatives and others to keep people safe. For example, a relative, friend or another care worker would remain with a person whilst the live-in carer had their daily break.
•□Risks assessments had been completed in relation to people's mobility needs, falls and medicines management. Environmental risks had also been assessed, and included an assessment of potential infection risks.
•□Staff had received training on infection control, which gave them the knowledge and skills to provide hygienic and safe care; supporting the reduction of contamination and spread of infection.
•□Live-in carers told us it was their responsibility to communicate any changes in people's risks or care needs so these could be reassessed and the relevant support plans adjusted.
•□We spoke with a care manager who had received information about a situation which required their attention. They had gone to great lengths to review the needs of this person (and their household), to ensure suitable support continued.
•□Monday morning meetings had been introduced so that any queries, problems and risks which had occurred during the managers' weekend 'on call' period could be followed up.
•□Improvements to the live-in carers' 'handover' process had been recently introduced so that information about people's risks and care were effectively handed over. This was to be completed where the live-in carer was new to the person. Care managers had been facilitating handovers where the needs of the person and household were more complex.
•□Spot checks were being widely promoted with people who were reluctant to have regular care reviews so that care managers could assess and review people's care and safety.

Staffing and recruitment.

•□There were arrangements in place to ensure there were enough recruited staff, at any given time, to meet the demands of the service.
•□At the time of the inspection, the agency had recruited one new care manager and was in the process of recruiting two further replacement care managers. There had been a period when existing care managers had needed to pool their resources and support each other's geographical areas.
•□Previous trends, patterns and forward planning helped the agency managers ensure they could meet future demand and cope with unplanned circumstances. Many live-in carers had worked for the agency for several years and told us they were happy to be as flexible as they could be.
•□In making decisions about staff recruitment and staff deployment the on-going natural movement of live-in carers was considered. The recruitment of new live-in carers was therefore on-going each month.
•□People's preferences, live-in carers' holidays, travel requirements, staff sickness, individual staffs' experience, qualifications and personalities and staffs' cultural diversity were all taken into consideration during recruitment. Additional considerations had to include whether the live-in carer was a smoker and if they held a driving licence or not. Having a live-in carer who could drive was a common preference for many people.
•□The agency had met all planned live-in care requests over the 2018 Christmas holiday period. We were not aware of any circumstances, at any time, where an agreement to supply a live-in carer had not been met.
•□In response to some concerns reported in 2018, changes had been made to the recruitment and induction process. These changes assisted managers to make better staff choices.

Using medicines safely.
•□Staff received training to be able to support people with their medicines in their own homes.
•□People's medicine support needs were recorded in their support plans for staff guidance.
•□Changes in people's prescribed medicines or their ability to manage their medicines were communicated to the care managers by the live-in carers.
•□Suitable arrangements were made for the delivery and storage of medicines in people's homes. Following one report which highlighted an increased risk to one person involving the access to their medicines, alterations were made to the storage of this person's medicines to reduce the risk of unsafe access to these by the person.
•□New and improved records had been recently introduced for the recording of all medicines, which included, skin preparations, medicines prescribed to be given "when required" and those brought over the counter. At the time of the inspection these new records were being introduced to staff during their attendance at an annual refresher course.

Learning lessons when things go wrong.
•□Live-in carers and office staff understood it was their responsibility to be honest and open and to report to managers things that had gone wrong or not gone to plan.
•□When reviewing and investigating safety and safeguarding incidents or reported concerns, agency managers had involved and liaised with relevant external services, local authorities, people and their representatives.
•□There was evidence that active learning and reflection was used to help improve the service moving forward.

Good

Is the service effective?

Our findings

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

Good: People's outcomes were predominantly good in terms of how their care and support was delivered by their live-in carers. People's feedback confirmed this.

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

- Most people and their representatives reported being very satisfied with the way their care needs were met by their live-in carers. Comments included, "We have been more than happy with the care provided by the live-in carers", "The carers have been well-trained and are good at their jobs. Some have been excellent" and "The quality of the care received from the carers is generally excellent."
- People's needs were assessed prior to the agency providing a live-in carer.
- People's choices and preferences about how they wanted their care delivered were explored with them and included in their support plan.
- In assessing and planning people's support care managers adhered to best practice guidance and relevant legislation.

Staff support: induction, training, skills and experience.

- All staff reported being able to contact the office if needed and could speak to a care manager if support was needed with a care issue.
- Evidence provided by the regional manager told us 59.6% (105 out of 176) live-in carers, in placements in January 2019, had received a support call from the agency's office.
- The company's policy was to provide staff with regular supervision (a one to one support discussion with a care manager) at least 'quarterly' or more frequently if required. Feedback from some live-in carers was that they did receive supervision but not as frequently as 'quarterly'. They said if they had any requests or problems they would contact the agency.
- The agency managers told us supervision was completed by care managers when they completed a 'client' review. They gave evidence which showed that 42 live-in carers had received supervision in January 2019. The regional manager had set a target for six to eight care reviews to be completed, by each care manager, each week. The regional manager monitored the completion of both review visits and the supervisions completed.
- We inspected the training manager's qualifications and looked at the content of the courses they had completed. These confirmed they held the appropriate qualifications and competencies to deliver staffs' training.
- Staff were complimentary about the training manager. Comments included, "She [training manager] is real, she has a fun way of putting the information over, so you can understand it" and "[training manager's name] brings it [the training] alive."
- Some live-in carers told us they would like to receive more training in dementia care. The agency planned to provide more of this in the future by utilising the knowledge of one care manager who had a degree in dementia care studies. Staff were also expected to improve their knowledge by accessing on-line training

courses. Since January 2019 staff had been asked to view a training video through 'Dementia Friends'. Staff could make requests for additional training which the agency would look to organise.
•□A formal process was in place to check staffs' knowledge and competency in relation to record keeping, the Mental Capacity Act, medication and safe moving and handling. These checks were recorded and where required, care managers provided further guidance or referred staff for additional training.
•□Newly recruited staff attended a five-day residential induction course at the provider's residential training centre. The course covered subjects which supported safe and lawful care delivery. For example, safe moving and handling, health and safety, infection control and awareness of the Mental Capacity Act. Cooking and housekeeping skills were also practiced and assessed during this time.
•□Each member of staff attended a mandatory day's annual refresher course.

Supporting people to eat and drink enough to maintain a balanced diet.
•□The support people needed with their dietary needs was recorded in their support plan. Also recorded, in relation to eating and cooking, was what people could do independently and what they enjoyed doing with their live-in carer. For example, eating together and preparing some meals.
•□Included in the support plans were any specific health related instructions. For example, one person's swallowing ability had been assessed by a Speech and Language Therapist (SLT) in 2018. They had recommended that the person's food and drink needed to be a specific texture and drinks a specific thickness to make it easier for them to swallow; reducing the risk of choking. This advice had been followed by the live-in carers.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support.
•□In some cases, live-in carers had needed to work alongside other care workers to ensure timely and consistent care was delivered to people.
•□They worked in conjunction with and followed the instructions of GPs, community nursing teams, physiotherapists, occupational therapists and mental health teams to enable people to continue living in their own homes.
•□Live-in carers organised and facilitated people's access to health appointments, if this was not done by their representatives, and they appropriately kept people's representatives informed of any health-related changes.
•□One live-in carer had liaised with professionals and organised the delivery of continence aids for one person. These were needed to help the person manage their continence needs and retain their dignity.

Ensuring consent to care and treatment in line with law and guidance.
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

•□We checked whether the service was working within the principles of the MCA. Live-in carers spoken with understood that people must be supported to make independent decisions where it was possible for them to do so.
•□They were aware of what constituted 'restrictive practice' and through review of people's care records, feedback from people and their representatives we found staff delivered care in the least restrictive way.
•□There were examples of live-in carers having protected people from or needing to report situations where the well-meaning, but misguided actions of others, could amount to a restrictive practice, which potentially

impacted on people's liberty.

• People who lived with dementia were for example, supported by their live-in carer to socialise in and outside of their home.

• The regional manager was not aware of any person, currently being supported by the agency, where an authorisation through the Court of Protection was in place to deprive the person of their liberty.

• People's legal representatives (those who held Lasting Power of Attorney for Finances and/or for Health and Welfare) were known to the agency and included in decisions made about the person's care. The regional manager was aware of when to report concerns they may have about a person's legal representative.

Good

Is the service caring?

Our findings

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

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity; Respecting and promoting people's privacy, dignity and independence.

- Most of the feedback we received from people and their representatives was consistently positive about how kind caring and compassionate the live-in carers were. Comments included, "The carer is kind and calm and [name of relative] likes her", "Care staff are charming and kind" and "[Names of two live-in carers] are both quite excellent and are dear and much appreciated good friends, and I feel very privileged to have enjoyed such excellent care."
- People and their representatives reported no concerns with how their diverse preferences or choices were met.
- People's feedback and care records told us people's privacy was maintained during care delivery. We observed one person's privacy be respected by their live-in carer when we visited them. The live-in carer enabled us to speak with the person in private. The same courtesy was afforded to this person's representatives when they visited.
- People's dignity was supported through the support they were given to remain independent, to make daily choices and be addressed in their preferred way.
- People were supported to remain socially connected with their friends and their community which also helped them retain their dignity. When visiting one person their live-in carer said, "We [the person and carer] have been entertaining all day, we have been out and had people to tea and we have had a lovely day." This live-in carer had chosen not to take their daily break which they were entitled to because they were enjoying spending time with the person they were supporting and had wanted them to have a great day. A neighbour made a comment about the live-in carer, they said, "Super girl, from South Africa, she's really lovely with [person's name]."

Supporting people to express their views and be involved in making decisions about their care.

- Live-in carers told us a large part of their role was to support people to express their views and to support them to be involved in making day to day choices about how they wanted to be supported. Some live-in carers needed to balance family expectations with the person's specific choices and preferences.
- In talking with one person about how they were supported to make choices and to express their views they said, "[Name of live-in carer] is excellent, we get on so well, that is so important for me." This person told us about how the health condition they lived with had an impact on them. They told us how important it was for the live-in carers to understand how to support them to express their views and to make choices. The person went on to say they had only had one live-in carer who could not communicate effectively with them. They said, "In the two and half years I have been with Corinium Care that's not bad."
- Another person who felt able and supported by both their live-in carer and the agency's office staff, to express their views and choices said, "Corinium keep in touch with the carer and, when appropriate with

me."

• One person's representative said, "Carers are respectful. Yes, I think they all are. They write down [relative's] likes and dislikes… they listen to what he says."

Good

Is the service responsive?

Our findings

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

Good: People's needs were met through person-centred care planning and personalised care delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control.

- People and their representatives confirmed they had been involved in the formation of their support plans and that these reflected their care needs and preferences. Support plans also included information about people's communication needs and how information needed to be shared with them.
- People received a level of service which met their needs, this included support to pursue their interests, receive visitors and to socialise.
- In some cases, the live-in carer worked with people's representatives and visiting health professionals to adapt the person's environment, so people's needs could continue to be met in their own home as was their choice. Both the people we visited had required adaptions to their home. One person's home had needed to make space for a profiling bed, provided following a hospital admission and the other person's so they had better access to washing and toilet facilities.

Improving care quality in response to complaints or concerns.

- The agency had a complaints policy and procedures in place and people and their representatives were given information about this when they first started using the service.
- People and their representatives had telephone access to the agency's office and it was relatively easy for them to raise a complaint or express a dissatisfaction. Those received by the agency were recorded.
- We reviewed complaints received and recorded in January 2019. These had been fully investigated and action taken to address the issues raised. These were predominantly about poor matches between live-in carer and 'client'.
- We reviewed the investigation records of previous concerns and complaints, which had been previously reported to us. Although sometimes difficult to ascertain if these had been fully investigated and addressed from the paper 'Complaints Form' used, following further discussion and review of other relevant records, this showed that complaints and reported concerns had been fully investigated and followed up. The provider also subsequently forwarded information about one complaint to show that electronic records had also been kept. These showed that the issues raised had been investigated. They also showed there had been dialogue between the complainant and the agency's manager during this process.
- The regional manager had identified trends and themes from previous concerns and complaints. They had based their improvement actions around these which included, staff from the 'bookings' team spending time on assessments with care managers, so they had a better understanding of what needed to be considered when matching clients with live-in care staff. There was now a process for informing people and their representatives about any changes in their care manager.

End of life care and support.

- People's end of live wishes were explored with them (where possible) or with their representatives, so that live-in carers were aware of what these were and able to meet these at the appropriate time.

• People were supported to have a comfortable and dignified death, in their own home, if this was their wish.
• Live-in carers worked alongside other health professionals to support people at the end of their life as well as their family and friends.

Requires Improvement

Is the service well-led?

Our findings

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

RI: Service management and leadership had been inconsistent. People's experience of using the service differed. Most people had experienced person-centred care, but they did not always consider the service to be well managed.

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on their duty of candour responsibility.

- Some people and their representatives told us they used the service because it had a reputation for providing high quality live-in carers and bespoke personalised care and this is what they had always been provided with. These people's and their representatives were aware there had been several in staff and managers, but this had not had a negative impact on them. One person's representative said, "We are thoroughly happy. We have regular live-in carers as well as live-in carers organised in-between who understand [relative's] needs." A person who received care support from the service told us they were very happy with the service given to them, both currently and in the past.
- Others told us they had been delighted with the service until there had been several changes in care managers. They told us they had experienced less well matched live-in-care staff as a result. They told us the agency was disorganised and communication with them had been poor. One representative said, "There have been a colossal amount of changes in care managers." This had continued to have an impact on them. Feedback also reported a drop-in support calls from the agency's office, both to the 'client' and their live-in care staff.
- Another person's representative described the agency's process of organising live-in-care staff as having been "shambolic". They said, they had been "left hanging" not knowing who the next live-in-carer was to be or when they were arriving. Despite many requests for this not to happen, they told us this had not improved. They said, "This is stressful for us and for [relative]." This representative went on to say they had experienced three changes of care manager in 18 months which they considered to be the main problem.
- Another representative told us they had not yet been given the details about the change of live-in carer, which was planned to happen, in two days' time. They felt confident a replacement live-in carer would be found, but they found the process of waiting for confirmation of this, stressful as they lived some distance from their relative.
- Other representatives told us they were still experiencing several changes in live-in carers, when the planned period for a live-in-carer came to an end. This had not been their expectation of the service. One person's representative told us they had specifically chosen Corinium Care because they advertised continuity of live-in care staff.
- Some people over the Christmas and New Year holiday period told us they had been allocated live-in-care staff who had not been suitable to meet their relatives' needs. Where dissatisfaction with a live-in carer had been reported, the agency's managers had been open in discussing the problem and forthcoming in taking action to resolve this. This had included, replacing live-in carers and dismissing others whose performance had not been satisfactory.

•□The provider informed us that changes to live-in care staff sometimes had to happen in response to clients' specific needs, client choice and the need to replace carers to ensure health and safety requirements are met in challenging positions.
•□Duty of Candour had applied, apologies had been given and, in some cases, financial reimbursement had been provided where the service had failed to provide an effective service to people.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements.
•□Since the last inspection in October 2017 there had been three different managers in post; responsible for managing all aspects of care and care related issues. At the time of the inspection there was not a registered manager in post. The last registered manager had left in July 2018. A new manager had been employed in September 2018 but left in January 2019.
•□A regional manager was acting as interim office manager and interim care manager at the time of the inspection. They had begun in their role as regional manager in November 2018 and had a wealth of relevant experience. They planned to register with the CQC to be registered manager of the service until a new permanent care manager was recruited and applied to be registered manager.
•□An audit had been completed on behalf of the provider in August 2018 and actions for improvement had been identified. By the time of the inspection some of these had been completed. The regional manager had also completed their own audit of the existing systems and processes. At the time of the inspection they were working to complete actions for improvement from both audits. We reviewed these audits and saw they had made significant progress.
•□The regional manager was fully aware of the staff culture. Some staff had not been working to the expected standard and others felt disengaged. The regional manager had made additional arrangements so that staff were informed about the changes being made and received explanations on other internal queries which were causing concern, such as pay.
•□Further support of the actions for improvement had been provided by the Regional Manager, since they had become more involved in the day to management of the agency's office. Time was still needed for these improvements to be embedded and sustained.
•□These had included working closely alongside, a predominantly new office team, and providing them with support and guidance to help them understand their roles and their responsibilities. At the time of the inspection the office teams ('bookings' and 'client' contact teams) were working more cohesively and effectively together. Some staff from the 'bookings' team had shadowed care managers when they carried out people's assessments. This was to help them understand better what needed to be considered when matching live-in carers to people's needs and preferences. The plan was for more members of the team to do this. Time was also needed for this to happen and to show whether this additional mentoring would improve matching outcomes for people.
•□There had been more supportive contact with care managers. The regional manager was acting as direct line manager to the care managers who told us it was reassuring to be able to have contact with them when needed. The recruitment of two new care managers had taken place and one other potential candidate had been identified. Time was needed for this team to be fully functional. The provider subsequently confirmed that three new care managers had been fully recruited.
•□The regional manager completed on-going audits and checks to help them monitor compliance with regulations, assess operational needs and to monitor the agency's overall business performance. They provided regular reports to the Directors of the company.
•□On-going quality and business audits were also completed on safeguarding notifications, investigation reports, accident and incident reports, staff supervision and training, staff recruitment including numbers of newly recruited staff, staff turn-over and staff skills, support calls to 'clients' and staff, care reviews visits, staff supervisions and spot check visits by care managers.

•□Care managers audited people's support plans, staff daily records and medicine records. A selection of these records were also audited by the regional manager on behalf of the provider.
•□Through auditing the regional manager had identified that previous and incorrect guidance had been communicated to staff, about what needed to be recorded in terms of mental capacity assessments and best interests decisions. Therefore, although care staff understood and practiced the principles of the MCA, the agency's records for recording mental capacity assessments and best interests decisions had not always been fully completed. Care managers had been asked to check all records relating to the MCA to ensure these records had been completed where required. At the time of the inspection this work was in progress and time was needed to ensure this had been fully completed.
•□Records relating to accidents and incidents, consent and investigations had also been identified through auditing, as needing improvement and action was being taken to address this. Time was needed to complete this work and ensure it was embedded in practice and sustained.
•□Regular meetings were held with senior managers and care managers who were involved in making decisions and implementing change and improvements. The above areas of improvement were discussed in these meetings. Further training on the management of investigations, complaints and accident and incident reporting was due to take place for care managers. Time was needed to ensure the improvement in practice from this training was embedded and sustained.
•□Meetings were also held with office-based teams and any issues or areas for improvement; around communication and business led objectives.
•□The regional manager was making sure that the provider's existing HR processes; disciplinary and probationary period were being used effectively to ensure only staff meeting the required standards remained working for the agency.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics.
•□Staff were kept informed of changes and adjustments to what was required of them through protected emails or protected texts sent from the main agency office. Live-in carer staff also had access to an internal electronic communications forum.
•□People and their representatives could keep abreast of relevant agency news through electronic and posted newsletters, phone calls and care manager visits. If needed information could be provided to people or their representatives in different formats to meet their needs.

Continuous learning and improving care.
•□There were examples of continuous learning taking place with improvements being achieved from this. One example included care managers taking back responsibility for following up safeguarding concerns within their own local authority catchment areas. This had been centralised by a previous manager but had proved difficult to manage; care managers had lost links with professionals in their own geographical authorities which had not been helpful in resolving issues.
•□Following the identification of a trend in poor quality support, provided by a few live-in carers employed in 2018, the effectiveness of the overall recruitment and induction process had been reviewed. Action had been taken to ensure the agency was employing staff of a high calibre. To support this changes had been made to the interview process, which now included a face to face discussion with members of the HR department and recruitment manager. Observational assessments were also completed during the induction week by agency managers, which included how new recruits interacted with others around them during this time.

Working in partnership with others.
•□Where it was required staff worked in partnership with local authorities, local health professionals and

overseas agencies to meet people's needs and the requirements of the agency.