Caremark Limited

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Inspection report

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Date of inspection visit: 9 and 10 April 2015
Date of publication: 17/06/2015

Ratings

Overall rating for this service	**Requires Improvement**
Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 9 and 10 April 2015 and was announced.

Caremark Limited is a domiciliary care service that covers West Sussex. There are three area teams; Horsham, Pulborough, Storrington/Steyning. The service supports older people, people living with dementia, people with a physical, learning or sensory impairment and those with mental health conditions. At the time of our visit, they were supporting 110 people with personal care.

The service did not have a registered manager. A new manager had been in post for six months but was not registered with us. They were due to begin the process of registration once checks with the Disclosure and Barring Service were complete. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People spoke positively about the support they received but expressed frustration over variation in their call times.

Summary of findings

They told us that this made it difficult to plan their day and some people found it confusing. They told us that staff were kind and patient. Most people received support from regular care workers who knew them well and understood their needs. They told us that they were involved in their care and that staff encouraged them to be as independent as possible.

The service was going through changes. The new manager had identified that the staffing levels had not kept pace with the growth of the service. They had put a stop to new care packages in order to stabilise and to improve the quality of the service provided. The management team was working to recruit new care workers and were reviewing some of the staff conditions, including unpaid travel time. In the meantime, supervisors and the manager were involved in delivering care to people. This was having an impact on the smooth running of the service as management and administrative tasks had fallen behind.

Improvements had been made to people's care plans and to how the call monitoring system was used but we found that audits, for example, in how medicines were administered, had not always been effective at identifying issues. The manager received support from a representative of the provider and new systems were being put into place, along with action plans to monitor progress. Staff spoke positively about the new manager and had confidence in their ability to make improvements. They felt able to approach the manager with suggestions or concerns and felt that they were listened to.

Staff did not feel they had received appropriate support and training. They were not satisfied with the induction training and did not feel sufficiently skilled or supported to carry out their roles. There were gaps in supervision, appraisal and refresher training for staff. A training administrator had been appointed and staff training provision was under review.

Medicines were not managed safely. The records in place did not demonstrate that people had received their medicines as prescribed. There were significant gaps in the records and confusion among staff as to which documents they needed to complete. The provider took prompt action to address these concerns and launched a full audit of medicines practice and records following our visit.

People's care had been planned and individual support plans were in place. **We have made a recommendation about how changes in people's needs are communicated to staff.**

Where risks to people had been identified these were assessed and actions had been agreed to minimise them. People received support to prepare meals and, where necessary to eat and drink. **We have made a recommendation about how food and fluid monitoring is recorded.**

People were involved in determining the care that they received and staff understood how consent should be considered. Staff were vigilant to changes in people's needs and their support was reviewed when required. If people required input from other healthcare professionals, this was arranged. Staff often supported people to attend GP or hospital appointments.

Staff understood local safeguarding procedures. They were able to speak about the action they would take if they were concerned that someone was at risk of abuse. Where concerns had been raised, these had been reported.

People were asked for their views on the service provided and understood how to make a complaint if necessary. They told us that the manager or office staff usually responded promptly to their concerns.

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

Summary of findings

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 safe.

Medicines were not managed safely.

People's calls were covered but the service often used management or trained office-based staff to make up for a shortfall in care workers. The service was currently recruiting to ensure that they had enough staff to meet people's needs consistently and safely.

People said they felt safe and comfortable with staff. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place to provide direction to staff and promote people's safety.

Is the service effective?

Requires Improvement

The service was not effective.

Staff had not received appropriate support or training and did not all have the knowledge and skills needed to carry out their roles effectively.

Staff understood how consent should be considered.

People were offered a choice of food and drink and given appropriate support if required, but their intake was not effectively monitored.

The provider made contact with health care professionals to support people in maintaining good health.

Is the service caring?

Good

The service was caring.

People were very complimentary about the staff. They told us that they were kind, helpful and cheerful.

Staff involved people in making decisions relating to their daily needs and preferences and supported them to maintain their independence.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

Changes to people's care needs were addressed but staff were not always provided with up-to-date written information.

Requests for ad hoc changes to call times were usually accommodated but people found the variation in their regular calls confusing and disruptive.

Summary of findings

The service listened and responded to the experiences of people, their representatives and took action to address their concerns.

Is the service well-led?

Requires Improvement

The service was mostly well-led.

The manager and supervisors were not able to focus on their roles because they were compensating for a lack of care workers by covering people's calls.

Checks and audits had not always been effective at identifying areas for improvement but new systems were being put into place along with action plans to monitor progress.

There was a new manager in post who was not yet registered with us. They were making changes and improvements in the running of the service.

The culture of the service was open. People and staff felt able to share ideas or concerns with the management.

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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 9 and 10 April 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

Two inspectors and an expert by experience in older people's services undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection, the provider completed 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. We reviewed the Provider Information Return (PIR), two previous inspection reports and notifications received from the service before the inspection. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing potential areas of concern.

We visited the office where we met with the manager, the commercial manager, the regional support manager, the training and recruitment administrator, one field care supervisor (FCS) and two care co-ordinators. We spoke with six care workers by telephone. We looked at 14 care records, eight staff files, staff training and supervision records, medication administration records (MAR), visit comment sheets, quality feedback surveys, minutes of meetings and staff rotas. We then visited four people in their homes. The following week we telephoned people to ask for their views and experiences. We spoke with 17 people and five relatives by telephone.

The service was last inspected in August 2013 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

People did not express concern over how staff supported them with their medicines. We found, however that medicines were not managed properly or safely. Records of medicines administered or prompted did not demonstrate that people had received their medicines in accordance with the instructions from their GP. Medication Administration Records (MAR) contained significant gaps. In one person's MAR from 19 to 31 March 2015, a daily medicine had only been signed for on six of the 13 days. Another medicine due to be given once a day was recorded as being administered at 6am and 7pm on three of the dates. A third medicine prescribed to be taken twice daily had only been signed for on seven of the 13 days in the morning. There was no record of administration in the evening during the period. One care worker told us, "Sometimes MAR sheets are not signed and log sheets not completed. When you come in and a blister pack is empty but there is no record it's difficult, I do tell the supervisor".

The service had different MAR and prompt records for people funded by the local authority and those who privately funded their care. We found that the records were in confusion, with prompt sheets used for those where staff were responsible for administering and administration records used for those where only a prompt was required. Audits of the MAR were not always effective. The audit of one set of records had concluded that there were, 'No issues'. We found, however, that the MAR was marked with an 'X' on a number of dates. The key indicated that this signified 'self-administered'. The care plan stated that the person required a prompt to take their medicine. The audit had not identified that a MAR was not required in this case. We discussed this with the manager who confirmed that the system was, "Confusing".

Where medicine had been prescribed on an 'as required' (PRN) basis, the instructions in place for staff lacked detail. An overview was provided which described what the medicine was for, such as, 'Pain relief', 'Relieves nausea' or, 'Treats fluid build-up'. There was no information on when the medicine should be administered or any detail as to adverse effects that care workers should be mindful of. The only instruction for staff was to give the medicine, 'if required'. When medicine was prescribed on a variable dose, for example, 'Take one or two paracetamol', the number of tablets given was not recorded. This meant that medicines may not have been safely and consistently administered to people.

Staff received training in medicines and their knowledge was assessed at the end of their classroom based training. Most staff were satisfied with the training they had received. One care worker, however, said, "I am not happy about the training Caremark give on medication. We are in charge of very strong tablets, if we give the wrong tablet at the wrong time that's dangerous". The provider had a system of practice observations which were used to check staff competency but these had not been routinely completed. Some care workers who started in early 2015 had not yet had a competency assessment since they began working independently. This meant that any issues with their practice may not have been identified in a timely way to ensure that people received safe care with their medicines.

The above was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We discussed our concerns with the manager, commercial manager and regional support manager during our visit. The commercial manager said, "We need to get it done ASAP, it can't wait". Following our visit, the regional support manager wrote to inform us that an action plan was in place. This included an audit of all customer files, the retraining of staff and consolidation of the MAR and prompt records in use. In the instructions to staff we read, 'After the recent CQC inspection it became evident that there were huge weaknesses in medication administration and documentation. Due to these findings all customer files must be completely audited'.

All of the staff that we spoke with expressed concern over the staff numbers. They told us that the lack of care workers made their work stressful. People told us that they received a schedule in advance and that the times were generally adhered to. One relative told us, "They are most reliable". We found that calls had been covered but that in order to do so, the field care supervisors and trained office-based staff had been required to fill in gaps. One care worker said, "A few of my calls are double ups and a lot were unallocated which I wouldn't find out until I turned up, they have sent staff out from the office when there is not enough". We noted that concerns had been voiced by staff

Is the service safe?

in staff meetings during February 2015. The manager explained that the service had put a temporary hold on accepting new customers. He said, "We're focusing on who we've got at the moment, we're not taking on new packages" and told us, "I have to put a stop to the growth until we can do it safely". A care coordinator said, "If I haven't got the staff to cover it, I reject packages". They told us that they had the support of the manager in doing so.

The service was recruiting, both locally and from abroad. They were focusing on recruiting to meet the business needs. For example, they were currently seeking drivers as they did not have sufficient staff to cover more remote locations. They were also reviewing staff conditions such as travel time and training attendance which were not remunerated at the time of our visit. We found that the service was taking steps to address the shortfall in staff numbers and to mitigate the risk to people using the service.

Staff recruitment practices were robust and thorough. Staff records showed that, before new members of staff were allowed to start work at the service, checks were made on their previous employment history and with the Disclosure and Barring Service. In addition, two references were obtained from current and past employers and their qualifications were checked in line with information supplied on the application form. This helped to ensure that new staff were safe to work with adults at risk.

Before a person started to receive support from the service, risks to their safety were assessed. These included moving and handling, medication, personal care, eating and drinking and risks in the home environment such as trip hazards or pets. Risk assessments had also been completed for the use of specific equipment, such as catheters or gastrostomy tubes (a tube inserted directly into the stomach through which nutrition is delivered). In the case of the gastrostomy tube, damage to site, blockage of the tube and the risk of infection were all assessed. For each risk, mitigating actions were detailed. For example, in a risk assessment for falls we read, 'Ensure that I am wearing the correct footwear such as well-fitted slippers to help reduce the risk of me slipping when I stand'. In another for moving and handling specific instructions on using the commode included checking the condition and cleanliness of the equipment to minimise the risk of infection. In a third for the risk of burns, staff were directed to 'Check and record the temperature of the water, ensure it is between 36-40 degrees'.

Where people had presented with behaviour that might put them or others at risk, monitoring was in place. We noted that the monitoring information had been used to identify patterns and triggers. This demonstrated that people's needs were monitored and reassessed on a regular basis to ensure that they were receiving appropriate care. When accidents or injuries occurred, staff maintained accurate records. These included body maps to record the site of the injury. One care worker said, "I found someone on the floor who had just fallen, I made them comfortable on the floor and then called the ambulance and the FCS. I followed the ambulance staff instructions and then completed an incident report". Risks to individuals were reviewed on a monthly basis as part of their care plan review. This helped to ensure that the person received safe and appropriate care and that staff were not put at risk.

There was a call monitoring system in place. Care workers were required to log in and out of a call using the person's landline. If the call was not logged as in progress 15 minutes after the scheduled start time, an alert was generated. This helped to ensure that calls were carried out as scheduled and that people received timely support. There was an out of hours' number which was covered by senior staff 24 hours a day. This provided support for people and care workers who needed advice or urgent assistance. For untoward events, the service had a business continuity plan which described the action staff should take in the event of an emergency, such as traffic delays, a fuel shortage, the office being inaccessible or a failure of the telephone system. This demonstrated that the service had considered risks to the health and safety of people using the service and had taken reasonable action to reduce them insofar as possible.

People told us that they felt safe and comfortable with the care workers who visited them. One said, "I feel safe and I have no concerns, I would speak to (the Field Care Supervisor, FCS) in the office if I did and she visits me quite a bit".

Staff had a clear understanding of safeguarding. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of

Requires Improvement

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harm. They told us that they received regular training in safeguarding and that they felt confident to raise concerns with their supervisors or the manager. One said, "We have regular training on safeguarding. Caremark go on about it a lot, it's most important. I look for physical and emotional signs, anything out of the ordinary, if I have concerns I would speak to the FCS or care coordinator, they are very supportive and ready to listen". Another told us, "I look for signs of abuse such as missing items, withdrawal symptoms, marks on the body, things like that. I would get my facts straight and then talk to the supervisor and complete an incident form which we have to hand in the folders". A member of staff who had raised concerns told us, "I wrote a report and took it to the office; I was pleased with the response". The service was proactive and had systems and processes in place to address and report concerns.

Requires Improvement

Is the service effective?

Our findings

People had mixed views as to the competence of the staff who supported them. One said, "I cannot fault them". Another told us, "They are pretty good and trained well enough". A relative told us that they had confidence that their loved one would be well looked after and that this gave them peace of mind. Another relative said that they had, "A fair amount of confidence" in the care workers but added, "If I wasn't there to demonstrate things they sometimes get in a bit of a muddle".

Staff expressed concerns over the training that they received, especially induction training for new staff. When a care worker joined the agency, they attended two days of classroom based training, one theoretical and one practical. They also completed e-learning courses and had the opportunity to shadow experienced staff. One recently recruited care worker told us, "Three days shadowing is not enough. More to the point is I only did a couple of hours each of these days. It is not adequate to show someone how to work, they just gave me the rota and said there you go". Another said, "I met the people and spent two days shadowing and then I was left on my own. The first time I was a bit scared as I didn't know them like you should do, the second time was better". This care worker did not know what PRN medication was and was unable to describe person-centred care. They told us, "If I don't understand something I just call up and ask". A more experienced care worker said, "There are not enough staff or staff that are competent. I don't know if new staff that have gone through their induction are taking on board the training". Another told us, "I am quite happy with the training apart from the manual handling and using the equipment. I would like to see more training on this given to the new staff".

The commercial manager told us, "We train everybody whether they have experience or not because they need to work to our policies and procedures". The training administrator explained that new care workers were signed off to confirm they were, "Safe to leave as competent to deliver a Caremark customer service". This included an assessment of their competency in the areas of moving and handling and medicine administration at the end of the classroom training. The competency of new staff should then have been assessed through the provider's system of supervision. For care workers, this included observations of practice on medicines management and moving and handling. We found, however, that these had not always been completed. Some new staff had been working independently for three months or more without a check on their practice. This meant that any issues or training needs may not have been identified in a timely way. One experienced care worker said, "I would like to see more training given to the new staff. They could improve such as with hoists and slide sheets - they don't know how to use them and this can be frustrating. I would like to see new staff working on double ups more before they are left alone, I think they need more experience, guidance and support". We found that new care workers did not feel appropriately supported in developing the skills and competencies required by the role.

Staff told us that they could make contact with their supervisors or the manager if they needed assistance. One said, "They have a 24-hour phone to call and I also have the manager's number as back up. I work a lot out of hours, evenings and weekends so for me it's vital". We found, however, that staff had not received regular supervision and appraisal. The service's policy stated that staff should receive five supervisions and one appraisal each year, with spot checks and observations of practice in addition. Where these had been completed, there was evidence to show that they had been effective. For example a care worker had raised concerns about their ability to safely move one person. The FCS had quickly visited the person to carry out a reassessment of their moving and handling risk assessment and support plan. The information that we were given suggested that approximately 30 percent of staff had attended an appraisal meeting in 2014 or 2015 to-date. A system of appraisal is important in monitoring staff skills and knowledge to enable them to deliver effective care. One care worker told us, "I have not had supervision lately, but have had them in the past. We used to have annual appraisals but I haven't had one for four years". Another said, "I have recently had a new line manager whom I see regularly but I have not had a written supervision for a while because she is catching up on herself". Staff told us that the FCS were regularly covering calls and as a result had not had time to carry out supervisions and appraisals. One said, "They haven't had a chance to become a supervisor yet as they are doing care calls".

Staff received annual refresher training. This included e-learning and practical training in moving and handling, medication, safeguarding, infection control, food hygiene,

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fire safety and first aid awareness. We saw examples of letters sent to care workers advising them that they needed to update their training. Information submitted to the local authority in March 2015 stated that approximately one third of staff were not up-to-date with the provider's mandatory training. Most staff were satisfied with the training, although some told us that they struggled with e-learning. One said, "The classroom training is adequate but I am not so sure about the e-learning. I am used to a trainer coming in and just doing it on a computer doesn't help me, I may not understand it and there is no one to help me – I struggled with this". Another told us, "The training was OK when I first started, then a few years ago they changed it to online. I don't like it and I don't think it's adequate. I haven't had much training in the past four years". The lack of staff competency checks meant that the service was unable to assess the effectiveness of the training in place.

Staff had not received appropriate support, training, professional development, supervision and appraisal. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was taking steps to improve the training provision for staff. A training and recruitment administrator had been appointed in November 2014. Evaluation forms of recent training included positive feedback such as, 'Very good course and trainer'. One member of staff said, "We get annual training on-line, which is probably fine for me as a refresher and then I go to the office for manual handling and medication. The manual handling practical has been inadequate, it's nowhere near good enough for new staff, and I have heard they are making improvements to this". Another evaluation form suggested that, 'More time to practice' would be beneficial. The manager was reviewing the training on offer including looking at the range of topics covered. They told us that, "Dementia training is not as in depth as people are wanting". He explained that the management team were looking at options for new training in dementia and behaviour management, neither of which had been routinely available to staff, despite the fact that they supported people with these needs. New e-learning in dementia awareness and mental capacity had recently been made available as a first step towards meeting this training need.

People were involved in decisions relating to their care and treatment and staff understood how consent should be considered. When we visited people in their homes we observed that staff involved them in decisions and offered choices. We found, however, that some staff had a limited understanding of the Mental Capacity Act (MCA). People's capacity was assessed as part of the, 'Individual needs assessment'. The manager told us that this would be reviewed if changes were noted. A care worker told us, "Most people can make decisions. I would report to the office if a person refused care or could not make a decision". One member of staff said, "I talk things through slowly and watch for signs of agreement, I try to help people understand or the families advise". Another told us, "We are told we can't force people, all we can do is persuade them. For example with medication we just record refused on the MAR and report it to the FCS". In most cases people had signed their support plans to demonstrate their agreement with the care that was to be provided. The manager had not been involved in any best interest meetings but they demonstrated an understanding of their responsibilities under the MCA. Best interest meetings should be convened where a person lacks capacity to make a particular decision, relevant professionals and relatives invited and a best interest decision taken on a person's behalf.

People's needs in respect of nutrition and hydration had been assessed and the level of assistance they required was detailed in their support plans. Some people were assisted by their family, others required help from staff to prepare meals or support to eat them. Staff were well-informed as to people's needs and preferences. For example, one person had a specific dietary need due to a health condition and the care worker was able to list the foods that the person should not eat. Another care worker told us that the person they supported liked, "Chutney and salad cream on everything". Support plans included prompts for staff such as, 'Ensure table and drinks are next to (person's name)' or, 'I am generally able to prepare meals myself but may require support at times, please ensure that I have eaten when you visit'. A record of the support given was made in the visit notes. We observed one person as they were supported with their breakfast. The person was happy with the support they received and with the choice of food they were offered.

Where people were at risk of malnutrition or dehydration, food and fluid monitoring was in place. Whilst the forms were completed, there was no evidence that they had been checked to ensure that the person's needs were met. One care worker said, "I don't know if the food and fluid sheets

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are monitored, I assume the FCS should check". The forms recorded what care workers had given to the person to eat and drink but did not always include specific detail as to whether they consumed it. One care worker said, "I like to see they eat a good proportion of their meal if possible but if the meal is given at the end of the call it is not always possible". Another told us, "I do the meal straight away on a call so I can prompt to make sure they have eaten and finished, that's my trick". Fluid charts detailed when a person had a mug of tea or half a glass of water but did not include guidance as to their target fluid intake or the total that they had consumed during the day. **We recommend that the provider reviews its systems for monitoring food and fluid intake to ensure that these are effective in meeting people's individual needs.**

Where healthcare professionals were involved in people's care, this was documented in the care plan. People told us that care workers had accompanied them to hospital or GP appointments. One person told us, "They came to the hospital with me and brought me back. It gives you that bit of confidence to see a friendly face". We found examples in people's records which demonstrated that staff were vigilant and took action to ensure that people received ongoing healthcare support. In one case the care worker had noticed blistering and swelling on a person's leg which was then referred to the GP. Another person's notes explained how the ambulance service had been called when a care worker arrived at a person's house and found them in pain. The outcome of the visits and consultations were recorded and used in reviewing people's care. One care worker told us, "I always speak to the FCS regarding healthcare. A couple of times I have been asked to contact other professionals under their instruction but I never make that decision on my own".

Good

Is the service caring?

Our findings

People were very complimentary about the caring nature of the staff. One person told us, "They always ask how you feel. They are genuinely concerned". Others told us, "They are friendly and chat to you", "They are helpful and cheerful" and said they are, "Extremely nice people". I know she is content when she is with them". Another told us, "They are lovely, kind and gentle, and they have a laugh."

We visited four people in their homes. We observed that care workers were polite and kind with people. We heard them chatting and laughing with people as they assisted them with personal care. People appeared fond of the care staff and comfortable in their company. One person said, "I am happy. I have got to know the girls and they are very good". One person had run out of marmalade. The care worker offered to bring some in on their next call, which the person was very pleased about. Another person told us, "She's (carer) very kind and helpful, she pops in to see you have what you want". Another told us, "They were extremely obliging and took my dogs out". A third said, "There have been times when they have over-stayed their period but she doesn't mind, we like to have a chat".

We observed that care workers treated people respectfully. People that we spoke with by telephone also confirmed this had been their experience. One person told us, "I have a shower every morning and I feel comfortable with staff regarding my privacy and dignity, I used to feel embarrassed with younger staff but they are all very good". A relative told us, "When they first came they asked him what he liked to be called. They speak to him and they don't discuss his condition over his head". One care worker explained, "Treat people how you want to be treated yourself, I would hate to be stripped naked! So I always pop a towel over people's laps, pull curtains closed and if family are around I tell them what we are going to do and get the person some privacy. If it is safe to leave someone on a commode I do". Another said, "It's all about them; I like to treat everyone as I would like to be treated or my parents – I always imagine them in that situation and give the respect they deserve".

Most people felt they had been fully involved in planning the care they received. Where people used communication aids or symbols, this was detailed so that staff knew how to engage with the person. Care plans included a section on the outcomes of the care and support. For example, 'With the support from my Care and Support Worker (CSW), I will be able to maintain my independence and remain in my own home'. For each element of the support provided, there was information on what the person could manage to do independently and detail of the support required. We read, 'Assist to sit on the bed, raise head of the bed to assist with sitting, CSW to support legs off the bed' and, 'I would like my CSW to give me a warm flannel so that I can wash personal areas and towel dry myself. I require support to dress'. One person told us, "They encourage me to do what I can do". Another said, "They are amazing. It takes me a long time to get up the stairs and they are really patient with me."

Staff explained how they involved people. One said, "I always ask them what they want me to do rather than the same thing every time and wait for their response". Another told us, "I give the person I am looking after the care they need and not always what I am told. For example if the person says they want something different, I do what they want. It's important to me to give the care people want and I always put people first, unless there was anything dangerous then I would tell the office". People had been involved in reviewing their care. One person had commented that the morning call was a bit late and that it had prevented them from attending some appointments. Following the review, the call time had been brought forward to accommodate the person's request. On one day a week the visit time had been extended to allow the person time to shower. People told us that the manager or supervisor visited them regularly to check they were happy with the care they received.

Information about people's background and interests was included in their support plans. We found details of people's work and travel interests, in one case the name of the football team that a person supported was clearly highlighted. Care workers then took time to get to know people individually. One told us, "I talk constantly to them and say, "Is it alright if I do this", and tell them what I am going to do. I know that what works for one does not always work for another so I really get to know them". Another explained that some people she supported were living with dementia and could become confused if she was wearing her hair differently and did not recognise her. She said, "I take my hair out if that happens as they will react differently". Staff spoke positively about the people they supported. One said, "I love my job, the clients they are so lovely".

Good

Is the service caring?

The service worked hard to promote continuity by trying to permanently allocate care workers to people. This helped them to get to know one another and for staff to better understand people's needs and preferences. A member of office staff told us, "I will permanently allocate as much as possible". A supervisor said, "Continuity and consistency are really important, people become used to carer's and they become part of the family. Particularly with people with dementia and younger adults we keep care staff to a minimum, it's what the family and we like to achieve. Younger adults can become upset when care staff change".

Most people we spoke with told us that they had regular care workers. One relative explained that they were about to be supported by a new care worker. They told us, "We have met and are aware of the new person coming in". Others had experienced more changes. One said, "I roughly have the same staff, new girls are not so good, but they are learning, they are 50/50 informed about me and what I like. They are on time and always come". In the provider's survey, 79 percent had agreed or strongly agreed when asked if they had regular staff visit them.

Requires Improvement

Is the service responsive?

Our findings

The primary concern that people shared with us was the variability of call times. They told us that they received a rota but that the scheduled call times could vary considerably from week to week. They told us that the times kept, "Chopping and changing" and that they were, "Very variable". Some people found this confusing and disruptive to their daily routines. One person told us, "Mornings are awkward with late calls. I am sometimes 14 hours in bed". Another explained that the visits had been carefully planned to synchronise with duties performed by nurses, but that the times were not always kept to. A third told us, "They dictate the times and sometimes these are not kept to." We found that the staffing levels did not always allow the service to respond fully to people's individual needs and requests.

There were positive examples of the service responding to people's individual requests. Some people told us that they had requested a change of visit time on certain days and that this had usually been accommodated. One person explained, "I asked them to come earlier on a Sunday so we can go to church". Another told us, "It took a little time to get through what times I wanted". Others told us that staff sometimes stayed over the visit time if this was needed. One said, "If I need a bit extra they are willing to stay". There were occasions when people had requested that a particular care worker did not visit them again and this had been arranged. A care co-ordinator told us that, "Some people just don't match. I then look at getting another carer in. I will then look at availability and times of the call if needed". On the system the service used, it was possible to indicate people's preferences for individual staff members. This was taken into consideration when allocating the calls and helped to ensure that people's wishes were respected and changes made in response to these.

When people's needs changed, the service took action to contact other professionals or to review the person's support plan. We saw examples of increased call times if a person needed more time on the commode, or felt they needed longer to shower or to have a bath. There were also changes to the staff numbers on some calls, such as to meet a person's increased support needs when they moved into and out of bed. One relative told us, "They cream his legs and they noticed blistering and puffiness and that's great because I would never have noticed that. I am calling the doctor". People told us that staff visited them to review their care. One said, "The FCS visits me quite a bit and is always asking if I am alright". Care workers told us that they were asked for their feedback so that people's support plans could be updated.

We found, however, that the information available to staff was not always promptly updated. Staff received a summary of needs with their rota. One said, "Some are out of date, I don't really use them much unless I go on a new call, and I do not always have adequate information". Another told us, "The time sheet information is not adequate or up to date. I have a person who came out of hospital a month ago; all it says on the information is 'ask office for details'. It should be updated". A care worker we met at a person's home told us that the person was presenting with confusion and was at risk if they went out of the house alone. They explained that on one occasion they had arrived at the call to find the person not at home. They had spoken with the office and appropriate action had been taken. The support plan, however, had not been updated to detail this risk or to describe the actions that staff should take in this scenario. Of the eighteen staff members who responded to the provider's care worker survey, approximately half felt that they were kept up to date when a person's needs changed. Some staff told us that they had noticed an improvement and that there had been work done to ensure that care plans were updated.
We recommend that the provider reviews its processes to ensure that staff receive accurate and timely information when people's needs change.

The service had a system in place to gather the views of people, relatives and staff. A client survey had been completed in September 2014 and a staff survey in February 2015. Due to the changes in management at the service, there had been some delay in analysing the responses but we saw that actions were in place to make improvements and address concerns. In response to feedback from people who said they weren't sure who the care manager or care supervisor was, information with photographs of staff was due to be sent out. People also told us that they were asked for feedback by the supervisors when they visited them in their homes and told us that the office responded to their queries or concerns. One person said, "One or two times I have had to contact the office. They have always been polite and helpful".

Requires Improvement

Is the service responsive?

People understood how to complain. There was information in their home files which described the complaints procedure and provided information on who to contact if they were not satisfied with the outcome. One care worker told us that a person had raised a complaint during a spot check. The complaint was that the carer was always running late for the call. They told us, "I looked through the rota and found I could make changes to get me there on time and it worked. I put suggestions forward if a problem is raised and I listen". Another person told us that they had made a complaint which had been dealt with to their satisfaction.

Requires Improvement

Is the service well-led?

Our findings

The staffing levels were having an impact on the management of the service and the ability to provide calls to people at regular times. People's calls were covered but in order to do this, office staff and the manager had often needed to step in. As a result the manager, supervisors and office-based staff were not able to focus on their duties which had an impact on the effective running of the service. One person told us that the day prior to our visit the manager had attended their call when the second care worker had not arrived. A member of office staff told us, "We do not pay staff for travel so it can be difficult to get staff to cover calls further away. Some people don't have anyone so it is paramount that we meet the call – it's challenging to do but they have to have it, if I can't get anyone out the FCS has to do it". The supervisors were stretched and had fallen behind with some paperwork and the supervision and appraisal of care workers. One care worker told us, "Supervisors need more back up, there is a high turnover and they are overworked and can burn out easily and when they go off we are left without a supervisor or someone who doesn't know our area". Some people commented on these changes, saying, "It's (the service) been wobbling and the wheels are coming off".

The service did not have sufficient numbers of staff to deploy. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service was actively recruiting for new care workers, especially those who could drive, and the manager was looking at some of the known barriers to recruitment. This included the fact that travel time and training attendance was unpaid. At the time of our visit, a new manager had been in post for six months. They were due to begin the process of registering with us as soon as checks with the Disclosure and Barring Service were complete. Staff were very positive about the manager and had confidence in their ability to bring about positive change to the service. One said, "The manager is good, efficient and has the right ideas, I have their mobile number, the back-up is brilliant". Another told us, "I think they are doing a good job, he will steer us in the right direction. It's always difficult to change but he'll pull it round for us, he is very approachable". A third told us, "The team dynamic is working really well. He does really support us as a team".

The manager was aware of the problems the service faced. Action had been taken to review and update people's care plans. Each revised care plan was signed off by the manager who told us, "Once we've reached the standard we can aim further". Due to the shortage of staff, which was impacting on the timing of people's calls and staff morale, the manager had put a stop to new care packages. He told us, "Right now we're not taking on anything big until we are more stable". Staff felt involved and regular staff meetings took place. One member of the office staff told us, "He has introduced regular catch ups and talks together and separately. We come together and give ideas, he asks what we want and what we think we need to do". A care worker said, "The manager is doing a good job and trying to implement their objectives and goals and get everyone on board with this. Unfortunately we have had a high turnover in management staff, but we are part of the new regime and we are trying to counteract the old ways". Another told us, "I am seeing the improvements now but I hope there are more improvements".

There were quality assurance systems in place at both manager and provider level. A representative of the provider visited the service monthly. In December 2014, they had carried out an audit of all customer and staff files. Comments included, 'No food risk assessment in place, 'No log sheets and been delivering care since June', 'Review out of date'. They told us, "They've been working really hard on care plans and risk assessments" and said, "They're working significantly better than they were". An action plan was in place and many of the actions listed had been completed. Speaking about the action plan, the representative of the provider told us, "It (the action) would stay there forever until it's gone". They told us that the service was, "Massively improving" and recognised the need to, "Stabilise before growing again".

Since the manager started in post, the focus had been on ensuring that care plans and risk assessments were improved and updated. One care worker told us, "There is more detail going into things like care plans and risk assessments". The manager also completed a review of incidents, daily log sheets and medicines records. Where issues were identified, memos were sent to staff and had been discussed in staff meetings. New bound log books had also been ordered to help manage the notes and ensure that a continuous record was maintained. The manager's audits were in the early stages and had not always proven to be effective. For example, the audit of

Requires Improvement

Is the service well-led?

medicine records had not identified the scale of the problem in this area. Following our inspection the provider notified us that a full audit of medicines had been launched and a four week deadline to make improvements set.

The manager had completed a quarterly monitoring report for the local authority in March 2015. This covered staffing, care reviews, staff training and complaints. Actions were in place to address shortfalls, such as in staff training. The manager had made improvements to the call monitoring system, which generated an alert when a call was 15 minutes overdue. The service had been receiving a high volume of alerts. As each alert was checked to ensure that the person received care, this was taking up a significant amount of staff time. The manager took action to remind staff about the importance of logging into and out of calls, they had also worked with the software company to identify issues. For example, when a person was ex-directory the call was not logged even when a care worker dialled in. The manager told us, "The number of call alerts has cut right down".

The service's aim was, 'To deliver the highest standards of professional care and support to those in need and who choose to remain living in their own homes'. Most of the staff that we spoke with were positive about the agency and felt that improvements were being made. One care worker said, "I would be happy to recommend this service to a loved one, that's the question we ask. You have to think would you want your family to receive this sort of service. I ask that about the organisation and care staff have to ask that about the care they deliver". Staff told us that the manager was open and made time for them. One said, "It's an open door policy, you just pop in and say you'd like a word and they have put themselves out for me". Staff felt confident to raise concerns and told us that they understood about whistleblowing. One said, "It's in the handbook and I would use it".

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Medicines were not managed properly or safely. Regulation 12 (2)(g).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The number of staff deployed was insufficient. Regulation 18 (1). Staff had not received appropriate support, training, professional development, supervision and appraisal. Regulation 18 (2)(a).