The Extra Mile Care Company Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection was carried out over the period of 1 to 24 March 2016. The inspection was announced. The Extra Mile Care Company is registered to provide personal care and support for people in their own homes. At the time of our inspection 480 people received care and support from this service.

We previously inspected the service on 26 November 2013 when the service was found to be meeting the regulations we looked at.

The Extra Mile Care Company had an interim manager at the service. This was because the registered manager had resigned from their post at the end of November 2015. 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. The interim manager was in their post whilst the provider was recruiting for a registered manager.

The Extra Mile Care Company had recently been absorbed within the Alina Homecare Group. The new parent organisation was reviewing the processes and paperwork across both organisations. The operational director told us they intended to use the best practice and processes from both providers to roll out across both organisations.

The majority of people told us the care they received from their regular carers was of a good standard, and that staff were kind, caring and always respectful towards them. Staff understood how to recognise and protect people from abuse and received ongoing training around how to keep people safe. Staff were not allowed to start work until references had been received and checks had been made to make sure they were suitable to work with the people that used the service.

People told us that they felt confident that staff had the knowledge and skills to provide the right care and support. We found that staff had regular refresher training in the main areas including safeguarding adults, medicines administration and health and safety, to enable them to deliver safe and effective care. Care staff received regular supervision or quality checks and care staff told us the training was of a good quality, although we identified some additional areas that staff would benefit from training/support in.

We could see from records that that staff responded quickly if someone was unwell and supported people to access other health professionals when needed. People were supported to take their medicine safely and when they needed it, and risk assessments confirmed the level of support people needed.

Most people's care records contained the relevant information for staff to follow to meet people's health needs and manage risks appropriately. Staff told us that in the main, they were made aware of any changes in people's needs in a timely manner. People told us they had choice over the support they received and nothing was done without their consent.

We found that care records contained detailed information but the lack of quality assurance processes meant some records we looked at lacked signatures and dates which meant it was difficult to tell how up to date information was. We also found some documents in people's homes did not contain the latest care records. The provider was aware of these issues and had recruited a manager to focus on quality issues and was due to take up the post in March 2016.

People had mixed views on the effectiveness of support from the office. Some people told us they felt the office staff were very responsive and had dealt with issues raised swiftly, whilst others felt that issues they raised continued to be problematic. We were told that care provided when the main carers were on leave, was not always of a good standard. Where formal complaints were made we could see these were dealt with efficiently and effectively.

The majority of staff were positive about working for the organisation. We observed through our discussions with the interim manager, the operational manager and the operational director that there was a culture of transparency in the service. They told us the provider was undergoing a period of change due to new ownership and they were committed to provide good quality care.

We found a breach of the regulations in relation to safe care and treatment.

We have made a recommendation in relation to care records.

You can see what action we told the provider to take at the back of the full version of the report.

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 always safe. People told us they felt safe with staff in their homes and staff were knowledgeable and able to tell us about different types of abuse.

Risk assessments were on the majority of files and were detailed.

Recruitment of staff was safe.

People told us replacement care workers did not always arrive on time and staff had on occasion hoisted people on their own as the second care worker had not arrived on time.

Is the service effective?

Good

The service is effective. Care staff received mandatory training in key areas and had regular supervision.

There was clear evidence of staff liaising with other professionals to response to changes in people's needs.

Staff understood the importance of gaining consent to provide care.

Is the service caring?

Good

The service was caring. People told us staff were caring and treated them with dignity and respect.

People were encouraged to be as independent as possible and involved people in the provision of their care.

Is the service responsive?

Requires Improvement

The service was not always responsive. Staff understood the importance of person centred care and regular care workers were knowledgeable about people's needs.

Formal complaints were dealt with effectively and in a timely way, but there were divergent views from people regarding the responsiveness of office staff to issues raised.

Not all care records in the office or in people's homes were up to date and there were quality issues with replacement care workers.

Is the service well-led?

Requires Improvement

The service was not always well led. We could tell from discussions with the registered manager and senior managers there was a culture of transparency and openness in the organisation.

Care staff spoke positively in the main about working for the organisation and the provider was introducing additional incentives to encourage and support staff in the coming months.

There were inadequate quality assurance processes which we saw impacted on care records at the office and in people's homes. We also heard from people using the service that the quality of replacement care workers was not always good. This had not been addressed by quality assurance processes at the time of the inspection, although the provider now had a plan to address this.

The Extra Mile Care Company

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.

The inspection started on 1 March 2016 and took place over nine days due to the size of the service. It was completed by 24 March 2016. The provider was given 48 hours' notice because the location provided a domiciliary care service and we needed to be sure that the interim manager would be available. The inspection was carried out by four inspectors for adult social care and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service. This included information provided by the service, previous inspection reports and notifications we had received. A notification is information about important events which the service is required to send us by law.

As part of the inspection process we met and spoke with six care staff in person and ten care staff on the telephone. We spoke in person with the training coordinator, the interim manager, operational manager and operational director.

We also looked at 17 care records and 13 staff records including recruitment and supervision details. We visited the homes of seven people who used the service, and spoke with an additional twenty five people on the telephone regarding the service.

We contacted two commissioners who work with the service for their views on the quality of care provided, and two health and social care colleagues.

Requires Improvement

Is the service safe?

Our findings

All the care staff told us there were sufficient numbers of staff available to keep people safe, and this was confirmed by people we spoke with. People told us they felt safe when carers were in their homes, "otherwise I would not have them here." Others told us, "I really trust my care workers", " I have never had any unease with the care workers when they were here, I must stress that" and "I feel safe in their company."

Most people we spoke with told us their carer workers came on time, but also said, "if there is a problem with lateness, it is usually when my regular care worker is away and I am sent a replacement." Some people we spoke with told us some care workers do not stay the full allotted time. One person told us the care worker is now very good, "rushes, but gets everything done, but my father has got used to it".

Care staff had differing views on whether they were given enough time to travel in between visits. Whilst one care worker told us "I feel I have plenty of time to do my work properly, without feeling I have to rush off to the next call." Another care worker told us the lack of travel time in between "means you don't have enough time to provide the care." We were also told "I feel I can give some people person centred care but I don't always have time to give person centred care to people who are very dependent. I report this to the office, who contact the social worker but it takes some time to get a reassessment." A person receiving the service told us "my care worker is good but always in a rush to get to the next job. She sees me in Barnet then has to travel to Wood Green then back to Barnet, no wonder she's late"

We saw on one person's record in their home where care staff had come two hours late for the morning call and one and a half hours late for the lunchtime call on that same day. Care workers also came an hour late for the morning call on the next day. The person who used the service told us how this impacted on their care, as it was too late for their shower on the day the care worker was two hours late and a family member had to make them lunch on that same day. They told us their regular care worker was off but they had not received a telephone call to notify them of the replacement care worker's lateness. We spoke with a team leader and the registered manager about this. They told us they had not been made aware of this situation and would seek to get an explanation for this very poor time keeping.

We were repeatedly told by people using the service that the service provided by the regular care worker was good, but the information they were given from office staff regarding replacement care workers, or people running late was not always satisfactory. One person using the service told us "the last couple of days has been very trying, [my] care worker is reporting in ill and I am advised a replacement will come, but no one turns up". This meant that some people were not receiving their care at the allotted time or on occasion, not at all.

The interim manager, operational manager and care staff all acknowledged there were some problems providing care to people who needed two care staff to transfer them safely. One care worker told us, "this used to be a problem, my partner would turn up maybe 20 minutes late. However, this is not a problem anymore, they seem to be able to manage it much better." Another care worker told us, "my double up calls are well coordinated by the office. My partner and I communicate and let each other know if we are running

a few minutes late. We also tell the office, who tell the client."

However, three care staff told us they sometimes had to move people with a hoist on their own because the second person did not arrive on time. One care worker told us "Sometimes the second person doesn't turn up for a double up so I have to do the hoisting by myself. This is not safe. If I wait for the double up I will be late for all the other visits." Another care worker told us "A few times the second person hasn't turned up and I've had to do the lifting by myself." The guide for care workers told them to ring the office if the second person for the 'double up' visit did not turn up.

The operational manager said they were exploring a variety of options to address the problem. One was to have set people who worked together to provide 2:1 care, as they could travel from one house to the next together to ensure they arrived at the same time. However, this impacted on people's choice of care staff. As a temporary solution the provider was limiting the number of new referrals for people who needed 2:1 care and was considering each referral carefully to consider if it was logistically possible to provide the service safely. She told us, "this has reduced the pressure on staff and we can focus on giving a good and safe service to those already within our service." The operational manager told us resolving this issue was a work in progress.

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

Staff had received training in safeguarding vulnerable adults as part of their induction. All the care staff were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures to follow.

Staff demonstrated an understanding of safeguarding adults and told us the signs they looked out for when they supported a person. One member of the care staff told us how they recognised possible signs of abuse, for example, if the mood of the person was different, "if they were not their bubbly self." Another told us, "just because a frail elderly person's skin bruises easily, we must not assume their bruises are related to tissue thin skin. I report every bruise I see." Care staff told us how abuse took different forms, for example, one member of the care staff told us how she had reported to the office manager her concerns about the consistent lack of food in a person's home. Another care worker told us they had made the office aware when medicines due had been missed. We could see from a record made by care staff in the home that a bruise had been noticed and the office notified for one individual.

With the exception of one member of care staff all knew what whistle blowing was and were able to tell us what they would do if they witnessed care they felt was of a poor standard. One person told us "I know what to do and I would not hesitate to raise concerns." We saw how whistle blowing was covered in the staff induction programme. Staff were clear they would speak with their line manager or an external organisation such as the local authority or the Care Quality Commission if they had concerns.

We looked at safeguarding records at the office. In the last 12 months there had been ten safeguarding referrals the provider had been involved in. We could see that the provider had made referrals to the local authority as appropriate and had followed up concerns with additional e mails where necessary. Where disciplinary action needed to be taken against care staff who worked for the agency due to poor care or recording practices, this had taken place. Records were well organised and up to date. At the time of the inspection an investigation by a local authority was taking place into a specific safeguarding incident. At the time of writing this report there was no information available relating to the outcome of the investigation.

The majority of the files contained completed risk assessments. These had been undertaken to assess any

risks to the person using the service and to the staff supporting them. However, we found four files did not have any dates or signatures of who had carried out the risk assessment. One file did not have a people handling risk assessment on file at all. We could not tell from these records whether these risk assessments were current or out of date.

Where these were completed fully they referred to environmental risks and any risks due to the health and support needs of the person. The risk assessments we read included information about action to be taken to minimise the chance of harm occurring. For example, some people had restricted mobility and information was provided to staff about how to support them when moving around their home and transferring in and out of chairs and their bed. We saw on care records that people required a variety of assistance to move or transfer. We saw clear instructions on one record about the safe use of a hoist. The risk assessment confirmed that the hoist had been recently professionally serviced.

Staff we spoke with demonstrated a good understanding of people's needs and the support required to promote their safety and wellbeing. Care workers were able to discuss risks individual people faced and speak confidently about how they maintained their safety. One told us, "my client sometimes forgets that they need to use a frame when walking. I have to gently remind them to wait until I put it close to them before they try to get up." Staff were aware of the reporting process for any accidents or incidents that occurred. They told us they report everything to the office, "even if I am not sure whether it is of significance."

We could see accidents and incidents were recorded and acted on appropriately. For example when a road traffic accident had occurred, even though it was no fault of the care worker, the registered manager sent out a document reminding staff not to use their mobile phones when driving and to be mindful of rushing and therefore being at increased risk of an accident. We saw a similar e mail sent to remind all care staff of the correct procedure for moving and handling following one incident with a care worker.

Thorough recruitment checks were carried out before staff started working at the home. We looked at staff records and saw how there was a safe recruitment process in place. We saw completed application forms which included references to their previous health and social care experience, their qualifications, their employment history and explanations for any breaks in employment. Each record had two employment references. We saw one staff record that contained three references on file, two of which were not very positive in relation to a person's punctuality and one said the person was not 'up to standard'. The third reference was fine. We asked the operational manager how they had ensured this person was suitable to work as a care worker. They could show us they interviewed this person in relation to the references, had discussed the issues and had carried out a quality check on the person within a month of them starting work. There was a reference verification form on each person's employment record where the reference was not on headed paper, which included a note, 'do employment dates match, and do reasons for leaving match.' However, it was unclear as to how these references were checked, and with whom. The operational manager explained they were due to start using new forms which would prompt staff to record more information fully.

We saw the provider had completed Disclosure and Barring Service checks on people prior to them starting work and their files contained the reference numbers. This meant staff were considered safe to work with people who used the service. We saw records of people's right to work in the UK where relevant. The operational manager could also show us they had a system for prompting them to check new paperwork when peoples' visas expired to ensure they were compliant with employment legislation.

The operational manager told us they focused recruitment in areas where they were receiving the most referrals. The new owner organisation had a central recruitment manager who provided recruitment advice,

but because of the size of Extra Mile Care they had committed to recruit an additional embedded recruitment co-ordinator. The operational manager told us they were committed to employing care staff from the local community as this meant they could address people's cultural and religious needs most effectively. Staff were also able to travel locally which was beneficial for them.

Care staff told us how medicines for those who used the service were in blister packs and "I just prompt, administer and support with medicines, and then record on a Medicine Administration Record sheet [MAR]." This was evidenced by records in people's homes. In exceptional circumstances, in order to be flexible and person centred, staff may prompt for medicines that were prescribed and not in blister packs, for example antibiotics, once this had been risk assessed by the office staff.

Good

Is the service effective?

Our findings

People told us when they were supported by their regular carer workers they felt staff had the knowledge and skills required to meet their needs. One person who used the service told us, "I am satisfied that the care workers who come here know what they are doing," another told us, "it is obvious that my care worker knows exactly what she is doing and how to do it." A relative told us "My mum gets the same care worker everyday three times a day,seven days a week. The replacement care workers try to accommodate my mother but are not very good at it. My mother since her stroke is not able to speak much,only the [main] care worker understands her". Another relative told us "The two care workers are both very good, but equally very different in styles, though we are both happy with them".

Training included a mix of face to face and e-learning (distance learning). Mandatory training included Safeguarding of Vulnerable adults; Mental Capacity Act 2005; administration of medication; manual handling and Health and Safety. We saw from the training matrix how most staff training was in date, or had a refresher date set. The training coordinator told us they monitored staff training and, "I send them an e-mail with the required distance learning attached." They also told us, "If people do not engage in the distance learning, then I will ask them to attend classroom learning."

Care workers we spoke with told us, "There is plenty of regular training." The office always reminds us when a refresher is due." One care worker told us, "the office leave nothing to chance; they make sure we are properly trained to do our job." Another told us, "the training here is superb. The company encourages us to develop ourselves." We saw staff could also access additional, 'stand-alone' training, amongst which included, diabetes, epilepsy, bedrail checks and stroke awareness. Where a new service user required specialist care, for example, with their PEG (Percutaneous Endoscopic Gastrostomy), we were told that the allocated care worker, "could not begin to work with that person until they had appropriate training from a nurse." A health colleague told us that the agency routinely referred their staff for training with PEG feeding. This was important as it ensured people were receiving nutrition from care staff fully trained with the equipment.

All staff were required to complete an induction programme which was in line with the Common Induction Standards (CIS) published by Skills for Care, and covered a broad range of topic areas including safeguarding, supporting with medicines, infection control procedures and health and safety issues. For those more recently employed members of staff, their induction followed the newly introduced Care Certificate Standards. Care workers told us they "shadowed a more experienced worker for a week before seeing a client on my own. This gave me great confidence."

We looked at the staff training matrix, and noted that for a large majority of care workers, their moving and handling training was in date. Whilst staff were very complimentary about the training in general, a number of staff told us there are a number of different hoists and tracking. One newer member of care staff said "I feel I should have had more training. I feel out of my depth if the other carer doesn't turn up". For those whose training was out of date, the training coordinator showed us a list of planned training dates, with care worker names against these dates, "I am committed to ensuring that everyone's moving and handling

training is up to date by the end of March."

We noted from our discussions with staff that many had not received end of life care training despite the fact that a number of staff were providing care to people with palliative care needs. Not all staff had training in diabetes care but most had a reasonable understanding of the signs and symptoms of a high and low blood sugar. One care staff told us that Parkinson's medication needed to be given at specific times but did not know the link between their medication and their ability to move. We were not aware any staff had received training in working with people with Parkinson's disease.

Care staff told us they received regular supervision from their line manager. Staff told us these processes gave them an opportunity to discuss their performance and identify any further training they required. We saw on staff records that supervision had been carried out regularly. We also saw how matters raised were addressed, for example, a care worker requested additional training in a certain area and we subsequently saw this had been provided. One care worker told us, "Supervision is supportive, not punitive." Another told us how they found it to be a "good opportunity to reflect on their work." We also saw from supervision records that quality checks were regularly undertaken with a majority of staff in people's homes as part of their supervision whilst ensuring care provided was of a good standard. We noted however, that newer staff were not subject to more frequent spot checks to ensure they were providing good care, and some care files had no spot checks to ensure quality of care was of a good standard.

We also noted that office staff had not received regular formal supervision prior to 2016, but the operational director told us as part of its commitment to quality improvements the new organisation had carried out supervisions with the office staff in February 2016 which would be ongoing. Monthly team meetings had also been put in place. The operational manager told us that they were in constant contact with the office staff and so were able to give advice on a daily basis. Care staff we spoke with noted varying levels of expertise or support from office staff. For example, whilst one member of the care staff told us "Communication is good. The office staff are very supportive". Another member of care staff told us "Sometimes I've called three times with the same issue on different days. It wasn't sorted out until I went to the office myself." Divergent views on the effectiveness of office staff were also given by people using the service and their family carers or friends. One person told us "the last couple of days has been very trying, [my] care worker is reporting in ill and I am advised a replacement will come, but no one turns up" Whilst another person told us "They changed my care worker when I told head office he was no good" The operational manager told us they plan to start regular supervision with the office staff once the new quality manager is in place in March 2016.

Staff were aware of and had received training in the Mental Capacity Act 2005 (MCA) as part of their induction. All demonstrated a clear understanding of it. One care worker told us, "I must let the person speak and make their own choices. I will offer examples of food so that they know what choices there are." Another told us, "I cannot assume the person lacks capacity. Once you get to know the person, you understand what they prefer, which makes it easier to offer them choices." People who used the service told us, "the carer workers always consult with me first before starting anything." Another person said, "they ask me before doing anything, even though they know what I always want" and "my care worker will always ask permission first and explain what she is intending to do."

We saw signed and dated consent forms on care records of those who used the service which related to the sharing of information and management of their medication. We noted that not all support plans [shift requirements] were signed or dated, including those in the person's home. We also noted how there was little recording of people's level of capacity on their records, especially where it was clear a relative had signed on their behalf. However, new paperwork to be introduced by April 2016 prompted more information to be provided that would enable care staff to understand more fully the impact of capacity issues in

relation to specific areas of a person's life and so was more person centred.

People were supported to access food and drink of their choice. Two people who lived together who both required support told us " They always ask us what we want to eat and they cook it for us". Much of the food preparation at mealtimes had been completed by family members and staff were required to reheat and ensure meals were accessible to people who used the service. However, one person whom we visited complained that they had been given undercooked food two days prior to our inspection. When we checked the care worker contact notes for that lunchtime visit, we found that there had been no record of the visit made. We later discussed this with a team leader who told us a relative had contacted the office about this and it was "currently under investigation."

We spoke to staff who told us how they understood the importance of good nutrition and hydration. A care worker told us, "I soon realised that the person did not like to eat their food out of the meals on wheels tray. I now put it out onto a plate, with a side salad and make it look nice, which encourages them to eat it all." A family carer told us "Oh yes definitely without a doubt they help my mother to stay healthy and well." Staff confirmed that before they left their visit they ensured people were comfortable and had access to food and drink.

We saw evidence on people's records of liaison with other professionals such as GP, district nurse and local authority social workers. One record we looked at had extensive communication between the provider, a district nurse, a care manager and hospital transport. The aim was to set up a complex package of care, which included the coordination of care so that the person was assisted to hospital on a regular basis for treatment. We saw from the person's care record that this package was established and regular.

Staff knew what support differing professionals could give, for example, an occupational therapist or physiotherapist provided advice on equipment to help people's mobility and independence. Staff told us that they would call the office staff if they found that a person was unwell when they visited. One care worker told us, "I would call the office and ring the relatives if a person was unwell and would call an ambulance if necessary. I would wait for the ambulance to arrive and ask the office staff to cover my next call." Staff told us that they would report any signs of a pressure sore to the office staff and contact the district nurses for advice. A member of the care staff knew how to reduce the risk by regularly changing the person's position.

Good

Is the service caring?

Our findings

People who used the service told us how staff demonstrated a caring approach to them. One person told us, "All of them are very respectful towards me and call me as I wish to be called." Others told us, "they are part of my home and they always go the extra mile for me," "they are very caring and gentle to me, they do a good job," "I welcome their company; it is nice to see them and have a chat" and "it is great to have such a good rapport with my care worker because she is really the only visitor I have." A family carer told us he "had nothing but praise for the[carers name] who is fantastic, if I could employ her myself I would in my own business." People who use the service and their friends/relatives were less positive about replacement care workers.

Staff told us that they usually supported the same people every day. One member of the care staff said, "this means that I get to know my client well and they become familiar with me." They also told us how, "the most important part of this job is to treat a client as you would expect to be treated" and, "if you develop a good relationship with a client, they are happy to see you." Another care worker told us "I treat them like I would my Mum and Dad." And "You have to talk to clients and treat them like family, smile and put your heart in it."

Staff were respectful of people's privacy and maintained their dignity. People told us, "They put a bath sheet around me to make sure I am decent and warm," and "They always make sure no one can see me when I am having personal care."

Staff whom we spoke with told us how they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls. A care worker told us, "I make sure I have a chat first and put people at their ease before starting their personal care." Another told us how they, "politely ask family members to leave the room whilst I help to wash their relative."

People were encouraged to maintain their independence and undertake their own personal care. Where appropriate, staff prompted people to undertake certain tasks rather than doing it for them. All those care workers we spoke with told us how important it was to encourage a person's independence, "no matter how little they can do for themselves, it is our job to make sure they retain that ability." We saw how people's care plans [shift requirements] included guidance for staff to encourage a person to, for example, "hand the flannel and encourage them to wash their face" or "encourage them to brush their own teeth."

A care worker told us how they engaged with a person who was totally bed bound, "I take along a newspaper and read to them when I have finished my tasks. That way, they feel a little involved with what is going on in the outside world."

Care records did not have a specific area to record people's cultural or religious needs. The operational manager told us at the moment they look through the paperwork they get from the local authority, and ask people at the assessment what support they require. This meant that care records were erratic in referring to people's cultural and religious needs, although nobody we spoke with told us their cultural needs were not

being met. The operational manager told us they matched care staff with the people they were caring for and they had a very diverse workforce that reflected the communities they served. They encouraged staff to talk about their cultural backgrounds to share understanding between workers and new paperwork being brought in by the provider imminently will require people to record more information.

Requires Improvement

Is the service responsive?

Our findings

The care records we looked at varied significantly. The majority of care records had care plans which were detailed, person centred and provided good information for staff to follow. Care staff told us "it gives good information about how to support them and will refer to the client's particular likes and dislikes too." We saw in some cases how relatives were involved in the development of care plans and were able to contribute important history and background. The interim manager told us that when the referral was planned, a person was assessed prior to the service commencing. At times, where the support was required on an emergency basis, the care worker was accompanied by a care supervisor, who then completed an assessment. People's care plans were developed using this assessment information.

However, nearly all records had documents on them that were not signed, so it was impossible to tell who had completed them. We also saw that eight files had documents that were not dated so we could not tell how up to date the information was. This meant that staff could not tell us with confidence when documents were last updated.

We asked care workers how any changes in a person's care plan were communicated to them. We were told how the office staff would ring them and let them know, and the care plan would be updated accordingly by a care supervisor. We asked the operational manager when information in the home was updated. She told us that office staff took out new information when they completed a review or there was a specific change in need. But she was not able to tell us how she checked this happened.

We noted that not all files in people's home contained the most up to date review of their care plan. For example, where we saw that there was a recently reviewed care plan on the office file, this was not copied to the file in the person's own home. One family carer told us "Replacement care workers have no idea what to do. They don't look for or use the care plan book".

The interim manager told us there was a delay in placing newer care plans on people's home files because, "there will be new paperwork and notepaper to reflect the new company which has taken over Extra Mile." She also acknowledged that updated care plans, irrespective of what notepaper they were on, would inform the care worker of the person's most up to date support requirements. This was particularly important for replacement care workers.

A person who used the service told us, "Although I know they are not medically qualified, they recognise when I am unwell and have had to call an ambulance on occasion." Another told us, "the care workers know what needs to be done because they follow what is in the blue folder." A person using the service told us how their care staff came at 06:45 one morning, an hour and a half earlier than their usual time, "so that they made sure I was ready in time for my hospital appointment." Most people told us they had no preference for either a male or female care worker, although they thought this would be provided if they had requested a specific sex and this was confirmed by the office staff. "However, we tell people that where there are two care workers required per visit, we are unable to supply two male care workers, but will always have one per double up call if requested."

Staff who provided regular care were knowledgeable about the people they supported. They were aware of their health and support needs, for example, a care worker told us, "I know how one of my client's need special support to move around. If I notice that their mobility has reduced, then I would let the office know immediately because they would need a reassessment." They were also aware of preferences and interests, for example, a care worker told us how one of their clients liked to wear a certain type of clothing during the day, and another told us, "one of my clients is very particular about the order in which I assist them to wash."

We saw how the provider responded to emergency requests for additional support. One record we saw included a request to double the amount of support a person was getting when their main family carer was admitted to hospital. Since this was an emergency, we saw evidence of e-mails which demonstrated the immediacy of the situation. The provider was able to set up a team of care workers within a very short period of time. This ensured the safety of the person and also provided a consistency of care from care workers whom they were familiar with.

In general, we saw there was good recording in the care worker's contact notes. This included a note of what the person ate and drank, and what their general mood and presentation was like during the visit. We looked at care worker records which were kept in the person's own home and saw that there were some instances where there was no record made of the care worker visit. In one instance, where a person had recently begun to receive three calls per day, we noted that that no record had been made for seven out of nine visits over a three day period. We discussed this with the interim manager who checked the electronic roster system and confirmed to us that the person had received their correct amount of visits but "the care worker had not recorded it. This care worker will be requested to come in for supervision and in addition, we shall spot check several of their records in client's homes." By the end of our inspection day, this care worker had been booked to come into the office to meet with a supervisor.

We looked at records of complaints in the 12 months to the end of Feburary 2016, there were 17. We could see that those recorded had been dealt with thoroughly and the complainant had been written to with the outcome of the complaint. People using the service told us they had the relevant numbers to call the office, one person told us, "I have no need to complain; if there was anything not right, I would tell my care worker."

Other people we spoke with had very divergent views. One friend of a person who used the service told us "They do not respect my friend's house, they drop and spill things on the floor. The office and the manager take no notice of my complaints what so ever". Another person told us "I had to put in a complaint via email with the Manager. She did put changes in place and addressed the issues really well. They have redeemed themselves. They were getting it wrong, now they are getting it right."

We saw from records that reviews did take place in the majority of care packages. But there was very little information recorded. It was not possible to tell from records that a home visit had taken place although we were advised all reviews were in person. Care staff told us they were not routinely involved in a review when office staff went to visit people in their home. The lack of information recorded and that care staff were not involved meant that the review was of limited value. We spoke with the operational manager who told us this will be addressed by the use of new paperwork and processes.

We noted from our discussions with people using the service and their family carers there was a significant difference in the standard of care when regular care workers were not on the rota to provide care. From the sheets we looked at in people's homes we could see there was continuity of care with a regular group of care workers in many circumstances, but when this was not possible people told us the standard of care provided fell dramatically. One person told us "Regular ones [care staff] are good, but the stand-ins, no!" A

family carer told us "My mother now declines replacements [care staff] if the main care worker is on a day off, however the care worker also pops over to check on my mother"

We discussed the issue of care provision when the regular care workers were either on leave or unable to visit with the operational manager. Where it was planned leave, the computer system for creating the rota could produce information on which care staff had visited people using the service, in the past, and taking into account stated preferences these care staff would be asked to provide replacement care. The computer system could also highlight when a new member of care staff visited a person receiving a service. This meant that office staff were prompted to ring the new care staff going in to a person. The operational manager told us the supervisor and care staff would often meet to plan holiday cover with replacement staff to share detailed information. When care staff could not attend at short notice due to illness or similar, this was more difficult to plan effectively. Although care could be provided by office staff who had experience of providing care.

The operational manager acknowledged the service was more successful at providing a good service when using regular care staff and undertook to try and improve people's experience of replacement care workers. A new staff post had been created and a person was waiting to take up the post. The person in this role will support the interim manager with staff rotas as well as other tasks.

We recommend that care records held in the office and at people's homes are reviewed to ensure they contain up to date detailed information and that all records are dated and signed.

Requires Improvement

Is the service well-led?

Our findings

The Extra Mile Care Company had recently been absorbed within Alina Homecare Group. Extra Mile as part of the Alina Homecare Group had the aim of providing "compassionate care and support for people who cannot fully look after themselves, as well as providing services that enhance quality of life." They provided a 'Service User Guide' when they first offered a service to people so they have key information to hand.

Extra Mile provided all care staff with a set of 'Keys to Care'. These are small cards connected by a key ring, devised by the Relatives and Residents Association. They acted as a good prompt/reminder to care staff about issues to 'think' about, 'ask' and 'do' in relation to a wide range of areas and included continence care, eating and drinking, activities of daily living and privacy and choice. Their use had recently been evaluated by the University of Worcester and they had been found to offer "simple, practical tips" for front line staff, particularly those new to caring. We were told that as part of its commitment to quality improvement, the Alina Homecare Group was now trialling them across all of their branches to support new care workers and may expand this in time.

The new parent organisation was reviewing the processes and paperwork across both organisations. The intention was to use the best practice and processes from both providers and roll these out across both organisations. During the inspection we were shown new paperwork to be introduced which was more comprehensive and detailed and which would provide information on a wider range of areas than was currently collected. For example, there was a new section on decision making and communication. If this was completed it would enable care staff to understand more fully the impact of dementia/capacity issues in relation to specific areas of a person's life and so was very person centred.

The operational manager told us they were in close contact with key agencies locally. We could see regular contact with the local authorities they were commissioned by. They were also starting work with a Hospital at Home service for people leaving hospital who live in Haringey. The operational manager attended provider forums run by the local authorities they worked for. From these she obtained useful information and updates on practice issues.

As part of the inspection we discussed the service provided with the interim manager, operational manager and operational director and found them to be open and transparent in their discussions with us. The majority of care staff working for Extra Mile were complimentary about the organisation. We were told the management are "very approachable" and they operated an "open door policy." One care worker told us "They are a good company, much better than the one I worked for before. The management of the agency and the communication is brilliant. If things change they contact us by email or post." Another staff member told us "I believe it is a very well-run company." However, we were also told "The support I get is very variable. Most of the office staff are excellent but a few are not competent." This divergent view was echoed by people using the service and their family carers.

We saw that regular bi monthly meetings took place with office staff to discuss current practice issues. Topics for discussion included how best to communicate with care staff and 24 hour support for live in care

workers. The operational manager had also held safeguarding meetings with office staff on three occasions in the last 12 months at which they discussed strategic issues. For example, safeguarding training, employing people with any offences and the range and scale of abuse they had encountered in the agency as opposed to individual safeguarding case work.

The operational director told us that they were keen to recruit staff of the highest calibre to work for them as they were aware their staff were their most important asset. In order to make working with the company more attractive we were told staff will be paid for attending supervision within the next six months. We were told the new owner organisation intended to increase the hourly rates for care staff working at weekends and had plans to introduce a limited number of contracts with set hours for care staff. Care staff are currently on zero hours contracts. In addition, the new owner organisation had started up a newsletter for staff, had plans to introduce a staff forum and introduced a monthly staff award with a £50 cash prize.

We saw evidence of a survey having taken place in July 2015 asking people using the service and their relatives their views. Forty one people using the service and 27 relatives responded. Questions asked covered areas such as politeness and warmth; ability to do personal care and domestic tasks and communication skills of the carers. People were also asked their views of office staff in relation to understanding requirements, appropriateness of care worker and resolving issues. Results were generally very good, with ratings at excellent, very good and good for the majority of domains. The lowest scores were in relation to care workers' communication skills with 4% being considered poor and 4% of office staff considered poor in relation to accommodating changes to visit times. A similar study of staff took place with the staff giving positive responses to the majority of questions. But sixty one per cent of staff said they didn't have enough information regarding clients.

Whilst we found there were a number of areas in which the service was well led, we found there was not sufficiently robust quality assurance process across the service at the time of the inspection. Whilst some files provided up to date information, we could not tell from others how old the information was. The registered manager was not able to tell us how they ensured the most up to date care plans and records were stored in people's homes. Whilst some telephone spot checks were recorded on care files, these were not on others and there was no robust system to check these were taking place.

We asked the operational manager how they knew when reviews were due. The computer system generated a list monthly which care co-ordinators were expected to complete. However, the lack of supervision of care co-ordinators and other quality assurance processes in place to monitor these meant that senior managers were unable to say with confidence reviews and checks were taking place within the timescales set by the organisation. We also found very divergent views of the service when talking with people using the service and their family or friends.

A health and social care commissioner told us there was evidence there had been increased issues with quality concerns, particularly in the last half of 2015. Issues identified were lateness, missed visits and problems with 'double up' visits. The commissioning organisation was of the view the service was committed to tackling the issues identified. The operational manager of the service told us that to assist them in improving quality assurance processes and dealing with complaints they had employed two extra staff. One new staff member would specifically look at quality issues, and the other would support the interim manager in relation to rostering of care workers and address quality issues in relation to them. One of the new staff started in post during the period of the inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Three care staff told us of occasions when they had used a hoist on their own due to the second carer not turning up on time or at all. This placed both the person using the service and the care staff at risk of injury.