Always There Homecare Limited

Always There (Crewe)

Inspection report

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Ratings

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

Overall summary

This inspection took place on 1 December and 10 December 2014 and was unannounced. At the previous inspection of this service we found that it was not compliant with the regulation relating to the management of medicines. The registered provider sent us an action plan detailing how they were going to improve this and at this inspection we found that the necessary improvements had been made.

Always There (Crewe) provides personal care and support services to people in their own homes. The agency is registered to provide services to older people, older people with dementia and adults who may have learning or physical disabilities, mental health problems or sensory impairment. At the time of our inspection there were 104 people who used the service in Crewe and 46 in Staffordshire. A further 25 people received a service commissioned by the Stoke on Trent local authority. A service for 17 people with learning disabilities was also provided across the Cheshire East and Cheshire West and Chester local authority areas. People who used this

Summary of findings

service also lived in their own homes but usually in group living situations with allocated staff to support them. People shared household bills and other tasks within these houses.

At the time of our inspection there was no registered manager at Always There (Crewe). However we were aware that the current manager was in the process of registering and this was completed a few days after the second day of our inspection. 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.

We found that some people who received a service from Always There (Crewe) did not always feel they could not rely on the service. Some people who received the service in their own homes told us that they did not think that staff had sufficient time to deliver the service they needed or had agreed. They felt that sometimes they could not be sure that they would know in advance who would be visiting them to provide care or that it would be someone they would know and who would know them. They told us that staff did not always attend at the times agreed. We found that staff did not always spend the amount of time at visits that had been agreed with people who used the service or the commissioners who had arranged the service for them. Where this happened it compromised the care which it had been planned would be provided. The registered provider had failed to ensure that people always received care that was safe and appropriate.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were not adequate systems in place across the whole service to make sure this did not happen. The registered provider relied mainly on systems installed by local authorities to monitor its performance. In those areas where these systems did not operate the manager did not have suitable alternative means of monitoring the service provided.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We found that staff were aware of what was needed to keep people safe from abuse or harm. Staff were well-trained. Medicines were stored and administered properly and staff acknowledged the important of acknowledging peoples' choices and preferences where they could. However some people felt that it was difficult to complain and some people who did complain did not feel that their comments resulted in the changes they wished.

You can see what action we 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 always safe because people told us they did not always feel they could rely on the service. People did not always receive visits at the agreed times and staff did not always stay for the planned length of time. Whilst people felt safe when they received care from staff whom they knew well they told us sometimes different staff would visit and sometimes without warning.

Staff understood what safeguarding meant and how to take action if they suspected it including "whistleblowing" if they did not think their concerns were taken seriously. Medicines were looked after properly and the risks associated with each person's care were assessed so that action could be taken to reduce these. In most cases the provider had taken steps to make sure that people employed to work in the service were suitable to do so.

Is the service effective?

Requires improvement

The service was not always effective. Some family carers felt they could not rely on the service particularly at weekends.

Staff were generally well-trained and arrangements were in hand to improve this where required. People told us that they felt that their regular carers knew how to provide care for them. When required staff prepared food properly and cleared away. Staff understood the importance of considering consent when providing care for a person.

Is the service caring?

Requires improvement

People did not always feel cared for.

Some people told us that they could not always be sure of receiving care from people who knew them. People told us they did not always know who to expect would visit them and that information about this was not provided consistently. When rotas were provided in advance the actual visits did not always match the information which had been supplied on them.

Most people felt that their regular carers provided a good service and looked after them well. People were provided with care plans and the service tried to match people's needs using this information.

Is the service responsive?

Requires improvement

The service was not always responsive.

Visits were not always of the required length which had been agreed and were sometimes too short to provide all the care tasks agreed. Some people felt they had been invited to be involved in their care plans but others did not or thought that it was some time since they were asked.

Summary of findings

People knew how to make complaints and we saw that these were sometimes responded to appropriately and in a timely manner. However we saw evidence that some people found it hard to communicate with the office in order to make a complaint and that even when they did improvement either did not happen or was not sustained.

Is the service well-led?

Requires improvement

The service was not always well-led. The manager had access to a number of systems which allowed her to monitor performance. However these were not available across the whole area served and therefore the manager was not able to provide the same level of monitoring across the entire area served by the registered provider.

The manager was taking urgent steps to make sure that the service conformed to the requirement that it had a Registered Manager. The manager was already aware of some of the issues we found at our inspection and was able to outline some of the measures she was putting in place to resolve them.

Always There (Crewe)

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 was 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 1 December and 10 December 2014 and was unannounced. On the first day two adult social care inspectors visited the offices of the registered provider and on the second day one returned. Two experts by experience were also part of the inspection team. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service in this case older people. The inspection team also included a specialist adviser with expertise in the care of people with learning disabilities.

The inspectors visited people in their own homes both in the Crewe area and Staffordshire areas. The specialist adviser visited two of the homes provided as part of the supported living scheme.

The provider gave us a list of people who used the service from which we chose 60 people. We wrote to these people saying we would like to contact them by telephone. Where a relative or family carer received the letter we spoke to them if they wished this.

The experts-by-experience spoke with 28 people who used services as well as 16 relatives or family carers. Inspectors spoke with eight people either in their own home or when they visited the office of the registered provider. Three people or their relatives contacted the inspectors directly when they heard we were undertaking the inspection.

We looked at 15 sets of care notes and seven staff files and spoke with seven care staff as well as care coordinators, the quality assurance manager and the manager. We looked at policies and procedures retained in the office as well as service audits.

We contacted the commissioning and safeguarding staff from the three principal local authorities in whose area the registered provider gave a service.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with told us that they felt quite safe or very safe within their own homes.

They said that they had no concerns of any kind in respect of the staff with whom they were familiar when they were visiting to support and provide their care. People told us, “Yes, I feel very safe with the girls who come here, always very kind and helpful”, “I have never ever had a problem with any of the carers, they have always been very good to me”. The people who lived in the group houses told us that the care staff were kind and nice to them.

Other comments people made included “(The carers are) lovely people, every one of them, I could not wish for better help than I get from them” and “Yes, I feel very safe indeed with the girls who come. I look forward to them coming”, “I get on with all the carers – I feel safe – I am not worried that they are going to abuse me”.

Family members sometimes relied on the service to provide care when they were unable to do so themselves or to give them a break as respite. Some told us that uncertainty about whether there would be sufficient cover could compromise the benefit they got from such arrangements. One family member told us “I feel there are not enough staff to cover and feel they are quite rushed and at times all they want to do is get to the next call “.

It is important that people eat at the right time and that their personal care needs are attended to promptly. On the other hand people who use services are entitled to some choice as to when they receive a service. One person told us “I don't think they have enough staff, I get rushed. I have diabetes and sometimes I get my breakfast late." This person told us that if the carers were late they might have to wait to be changed when they were wet and uncomfortable.

Another relative told us about an instance where a person had to remain in bed all the time and relied on care workers to call in throughout the day. Two calls had been missed meaning that this person had been left without any help for more than sixteen hours. In another instance a person had written in a survey that because the times for helping them with rising from and going to bed were not correctly observed they were frequently left in bed for 12 hours without being able to move or get up. The registered provider had failed to ensure that people always received care that was safe and appropriate.

This was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

When we visited Always There (Crewe) in 2013 we found that the service did not conform to the relevant regulation concerning administration of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. The registered provider sent us an action plan. At this inspection we checked that this plan had been implemented and saw that relevant risk assessments had been updated.

We saw that arrangements had been made for medicines administration records (MAR) sheets to undergo monthly quality monitoring to make sure that they were being completed properly. We saw examples where recording errors had been detected and corrected by this process and steps put in place to improve practice. We saw that after the last inspection the registered provider had arranged for a major training event to be provided for staff. We reviewed the content of this training which was appropriate to the activities of a domiciliary care or group living agency. One person told us “”Yes they know what medication I am on and give it to me”.

We were satisfied that appropriate and secure arrangements were in place for the storage of medicines however in one instance we were concerned that the written guidance for staff was inadequate. This related to the specific condition for which a person required the medication.

We checked the MAR sheets and found a discrepancy where one person was prescribed twice a day but double doses were being given once a day. The staff told us that they had been told by the person’s general practitioner that this was acceptable. As this was not recorded anywhere the supervisor decided to revert to the dosage as prescribed and clarify the situation.

Requires improvement

Is the service safe?

We saw that the registered provider was introducing a revised medicines policy across the company with an implementation date of July 2015. The manager told us that she was aiming to introduce these arrangements in advance and by January 2015.

We spoke to two people whose care involved the care staff handling their finances. They told us that they were satisfied with the service and one person told us that the carer always checked to make sure what they wanted and "always brings me a receipt for whatever they spend. I do trust them".

We talked with staff about what they understood by safeguarding. They were able to identify the sorts of abuse which might affect the people they provided care to and said that they would report anything they suspected to the manager. If this did not result in appropriate action then they would go higher either within the company or to an outside body such as the local authority or the Care Quality Commission (CQC). Officially this is called 'making a disclosure in the public interest'. CQC is one of the organisations prescribed for such disclosures.

Staff told us that they had received training in safeguarding both during their induction training and when they received periodic refresher training. We checked the provider's records and saw that the level of training completed in safeguarding stood at less than 75% in the Crewe service whilst the level in the North Staffordshire service was higher at 90%. We saw that the provider was taking steps to redress this with additional training being held on the day of our inspection. We saw that the registered provider had an up to date safeguarding policy which was displayed on the manager's notice board together with the safeguarding procedures for the local authority areas covered by the service.

During our conversations with people who used the service there were three incidents reported to us which gave cause for concern. These all related to the way in which care workers looked after the security of people's homes. In one instance we were told that a care worker had let themselves into a person's home without announcing themself properly. This person said they got a fright when they were confronted with someone who they did not know. On other occasions concerns were expressed about the way that coded locks or other security arrangements were managed.

We looked at care files in the home care service to see how the registered provider assessed, recorded and managed risks which might affect the care provided to people who used the service. These included risks from medicines, cleaning materials, and moving and handling as well as finance issues depending on the requirements of each person. We found that there were written risk assessments both in the files maintained at the office and in the care files which people allowed us to look at in their own homes. We saw that the assessments were up to date and had been reviewed. This meant that the registered provider could take these risks into account in such a way as to minimise them when providing people with care.

We looked at how staff were recruited by inspecting a sample of personnel files. We saw that the registered provider asked prospective employees to complete an application form which provided a full employment history and also asked for references so that the applicant's suitability to work in a care setting could be assessed. In some instances we found that both references had not been taken up or that the status of a referee had not been checked to make sure that they could vouch for the applicant. We brought these to the attention of the manager so that she could investigate them further.

We saw that Disclosure and Barring Checks (DBS) were made. DBS checks allow a registered provider to check information about any criminal convictions which an applicant has received and determine whether this would make them unsuitable to work in personal care. We saw that the provider also required staff to make an annual declaration of any convictions they might have received since the last DBS check and to undergo a fresh DBS check every three years. We saw that the manager monitored progress on obtaining these checks.

Some people and their relatives told us that they did not think that there were enough staff available to cover when other staff were sick. However we saw from the records supplied to one of the service commissioners that the registered provider regularly declined work because they did not have the capacity to deliver it. This meant that the registered provider was aware of the limitation that staffing levels placed on the level of overall service that could be safely provided.

Requires improvement

Is the service effective?

Our findings

People told us that they felt that the staff were usually well-trained and knew how to care for them. They told us "They have to use a hoist to bath my husband. There are always two of them. Sometimes a new one comes to learn but there is always one of the two who knows exactly what to do, and keeps him safe" and "Yes, my carer creams my legs, I do as far as I can do for myself and she finishes off. Yes she knows what to do and does it well".

We saw that staff were provided with an appropriate induction programme when they first joined the service. Induction training must be provided by employers within the first twelve weeks of employment to make sure that staff are ready to work with people in a particular setting and that they have the right skills they need to do the job. The registered provider required staff to attend a five day programme which included health and safety and fire awareness, adult support and protection, medicines awareness, moving and handling, nutrition as well as end of life care and dementia awareness.

We checked the training records kept by the registered provider to see if staff knowledge and skills were kept up to date. We saw that for the North Staffordshire area training had improved significantly over the last eighteen months with more than 90% of staff being recorded as up to date. Training in the supported living service was currently showing similar levels of completion. Training completion for staff working in the Crewe home care service was lower with around a quarter of all care staff awaiting training in moving and positioning, safeguarding, mental capacity and first aid awareness.

Staff told us that they felt they received good training from the registered provider. We saw that this was provided by a dedicated training officer who provided this face to face. We were told that every twelve months staff were provided with a full two day update of key areas of skills and knowledge and we saw that these sessions were taking place during our inspection of the offices. In addition to this the manager had arranged for a member of staff to received dedicated training in a specialised area of care to meet the needs of a new person who was about to start receiving a service. Providing training means that staff have the skills to provide care which meets people's needs.

Some family members of the people who used the service did not think that there were enough staff particularly at weekends. They told us "Weekends can be an absolute nightmare. Will they turn up or won't they?" and "(The carers) can be up to an hour late and don't let you know ….It's mainly at weekends and I think it is partly shortage of staff and partly bad management of the rotas". Two more family members told us "They sometimes seem short of workers and seem to have a lot off and lack enough cover for this" and "Especially seem to be short of drivers from what carers say. Told today that carer had had another four calls added on to her day "and "They will always be short of staff because they put on them, not a lot of cover, no back up".

We have commented on similar issues in the safe domain of this report where we have assessed them as in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We looked at the arrangements for staffing at the agency. We saw that staff were categorised as drivers and non-drivers. Where a person required care from two people such as where they needed to be lifted or moved the agency allocated a driver and a non-driver. Otherwise staff who were drivers undertook the majority of the calls where only a single carer was required. The registered provider's website claimed that "our care workers travel far and wide". However despite the use of cars staff appeared to work in "patches" or localities and we were told that there could be difficulties in getting staff to work even in the next town which was about 6 miles away.

We asked staff if they knew about the Mental Capacity Act 2005 which makes provision for what should happen if a person is unable to make certain decisions for themself. This could be because of an illness such as dementia or a learning disability. Of the staff we spoke with in the home care service, records showed that two had not completed Mental Capacity Act training. Training in the Act was much lower in the Crewe part of the service (at 67%) than in the others. Some staff in the group houses told us they did not have training in the Mental Capacity Act 2005 but training records showed that 84% of them had completed this.

However when we asked staff about how they managed issues of consent with the people to whom they provided personal care they showed that they had a working

Requires improvement

Is the service effective?

knowledge of and understood the importance of this. They said "We use our knowledge of the person (to be sure if they consent or not). I find out if they understand and explain what I am doing" and said that depending on the importance of the decision they would inform the office about any refusal to accept care or treatment, such as medicines. They also said that where appropriate they might refer to a social worker for advice about mental capacity issues. We saw evidence that such discussions had taken place regarding a significant decision for a service user in the group living service where their capacity to make this needed to be clarified. This meant that the registered provider was aware of the importance of making sure that personal care was provided with appropriate consent.

Where staff were involved in helping to prepare a meal for people we asked if they were satisfied with way that this was done. People told us "Yes, she (the care staff) gets me my breakfast when I get up. I decide what I want, usually porridge or cereals and toast. Yes, she does wash her hands, uses gloves and clears things away after she finished. She is very good" and "I am always asked what I want, I tend to have the same every morning because that is what I want. Yes, I think they have been trained to clear up afterwards and put things away. It only takes a few minutes to do my breakfast. Yes she wears gloves". Another person told us "Yes, does what I want for my breakfast, usually toast is enough when you get to my age. There is very little to clear up, but it is done". However another person told us that they felt they had to prompt the carers to wash their hands before preparing food. We saw that in the group houses people were supported to prepare their own food from menus chosen by themselves.

We saw from the care files that the service provided to people was arranged on the basis of a needs assessment which was completed with them. This meant that the care provided could be tailored to each person. Some people received visits to help them with important tasks such as taking medicines. Where this is the case it is important that the visits are scheduled so that the medicines are taken at the right time and that there is a sufficient interval between doses.

We were contacted by a local authority commissioner to express concern that the agency had been asked to provide care to a person who required medication at specific intervals otherwise they might receive either too much or too little. The agency had failed to time these visits accordingly. The manager told us that they were aware of this and had made efforts to improve the situation. One of the ways they had done this was by identifying a team of workers who would provide care for this person. The commissioning agency confirmed that there had been some improvement in the service provided.

Requires improvement

Is the service caring?

Our findings

Most of the people and their family members who we spoke with either by telephone or who allowed us to visit in them in their own homes were complimentary about their care workers. Carers were described as being “kind”, “caring”, “respectful”, ”sociable”, “friendly”, “efficient” and “patient”. People told us “Yes they do help me a lot. I would not be able to manage without them” and “Lovely girls, no one could treat you better than they treat me, always a joke and a bit of banter, it is so good to have them around”. Other people told us “I am really well looked after. They (the care workers) never leave me without asking if there is anything more they can do for me. Yes, they are special people”. We saw that in the group houses staff responded positively to the people who lived there and in a way that was consistent with their needs.

We noted that satisfaction appeared to be highest when people knew their carers well. One person told us “My carer is very good, I would not like to change her, she knows exactly what I like and what my needs are, she treats me very well. I enjoy exchanging family news and what is going on in the world – she is a tonic”. A family member reflected similar views when they said “Brilliant carers. Can’t fault anything. Pretty regular carers. Never had to complain once, love coming here and laugh and joke with us both. They are brilliant with my wife – beautiful I can’t fault them at all. Give them 11 out of 10”. Another person told us “Yes, I do get regular staff, I know them well, I would not want to change them” and “I have had new carers, everyone has to learn but it is nice when you get regular girls, they understand your needs and don’t have to be guided as much.”

Dissatisfaction was evident where people did not have regular carers. Some people who used the service complained to us that they did not have regular carers allotted to them – they said this particularly happened on evening and weekend calls. One family member told us “I don’t know who is coming in at the weekends, I have a rota, but it gets changed, no discussion, no warning. It's not right, not knowing who is coming to your home, it can be anyone. I don't like it. At night some of them are good, two are excellent, three others are OK, others - no - always chopping and changing …I feel I need more help. I am not too well myself. I feel I am a nobody". Other people said “I get too many carers at night” and “I get a lot of different carers – it is hard going”.

One person we spoke with told us that whilst they received care from a consistent carer on 12 mornings out of 14 (the other two days being the regular care worker’s rest days) “there are different ones at night”. This person told us that although they were provided with a written rota so that they should know who was going to visit them, the changes to the evening calls meant it was rarely of much use. Another person said “There are too many different workers at night time, sometimes you might know them at other times you don’t”. Some people expressed anxieties about being visited by care staff at night when they were unknown to them.

Although we found that most people were supplied with a rota which might reduce this anxiety people said it could not always be relied on. They told us ““Yes, you get a rota but you get different people coming, particularly at weekends” and “Yes, you sometimes get a rota but you can’t rely on who is coming”. The registered provider had failed to ensure that people always received care that was safe and appropriate.

We have commented on similar issues in the safe domain of this report where we have assessed them as in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The manager told us that a printed rota was issued at the end of the week and given to the care worker to deliver on their next visit but she was aware that this was sometimes missed. She told us she was considering alternative ways of delivering rotas to people.

We looked at some of the rotas for people who used the service. In one instance we found that there was a high level of continuity of care with a single carer providing care for an hour daily except for their rest days when a consistent replacement was substituted. In another instance though we found someone with similar requirements received care from four different people within a four day period and in another nine different carers visited a person over seven days. In a further

Requires improvement

Is the service caring?

instance there was some consistency around the morning call which required two carers with rather less in the evening, but the remainder of the visits were provided by five different staff in a three day period.

When we looked at the records for people who needed two carers to visit them the position was more complex. On one rota we could see that attempts were made to schedule at least one of the same staff in the morning on each day but beyond this there was no consistency in the care staff allocated to the three other calls. In a five day period a total of 15 different care staff provided the calls to this person.

We asked staff how they made sure that they cared for people with privacy and dignity. They gave us examples such as being aware of how a person wished to be addressed, making sure that the person was suitably covered so as to preserve modesty when undertaking personal care tasks, offering the person a choice of gender of the care worker, and explaining and gaining agreement if another person was observing practice, say when shadowing as part of induction. In the group houses we saw that people had their own bedrooms in which they could have privacy. We saw that records kept at the office were kept securely meaning that people could be sure that information about them was confidential.

People who used the service confirmed that in the main this was the case. They told us "When I have a shower and am helped by my carers, they always close the bathroom door. I am able to do a bit of washing myself, but I never feel embarrassed because they help me keep my dignity by covering me up as much as they can" and "Yes, I do think I am treated with respect. My carers asked what I would like to be called, when they first came to help me. I said my Christian name, we each call each other by our Christian names, I think it is more friendly".

A third person told us "I have always been treated with respect, I expect nothing less." We spoke with one person who had special dietary requirements on account of their religion and they confirmed that this had always been observed by the care staff. However two people told us that they had not been consulted about the gender of their care worker in advance. They told us "They sent a lad as one of my double up - not asked me if I minded a male carer. Told them no and it was sorted straight away" and "They sent a man without asking and I complained as not respecting privacy and dignity in my view and told them it must not happen again and it hasn't". The manager had briefed us about this situation when we arrived to start our inspection and we were satisfied that they were isolated incidents which the agency had resolved.

When we looked at care planning documentation we saw that people had been asked to sign their initial assessments to show that they agreed with them. When we visited people in their own homes we saw that documentation contained in that version of the care files was also signed by the person using the service. People told us that they knew about their care plans although they did not necessarily read them again after they had initially signed them. People living in the group houses told us that they were involved in decisions. One example we were given was about choosing who might come to share the house with them when someone moved out. They told us they were able to look at their care files and staff explained these to them when necessary.

Requires improvement

Is the service responsive?

Our findings

We looked at care files and saw that the documentation was written from the point of view of the person who used the service rather than from the point of view of the service and that a note was made of people's preferences such as in relation to food, gender of worker and whether care staff should wear uniform or ordinary clothes. This meant that the service could respond to people's individual needs.

The people we spoke with and their families all had care plans and some could recall being involved in and making decisions on the help and support they needed which allowed them to stay within their own homes. We saw that whilst people who used the service had a copy of their plan, very few said they had read it although they knew where it was and said that staff always wrote in the "blue book" when they were leaving. We saw that the "blue book" (or folder) contained the needs assessment, risk assessments, medicines administration records and a booklet which was used to record what had happened during each visit so that the next care worker would know what had taken place.

The registered provider offered care to people in different ways. Home care provided for older people was sometimes commissioned by the local authorities on the basis of tasks which required completion such as bathing, taking medicines or preparing a meal. We saw that this was the case at this agency when we saw correspondence from the local authority specifying the length of visits and the tasks to be completed. We saw that sometimes these visits were commissioned from fifteen minutes upwards.

However when we looked at a sample of the records of the visits that had actually been made we found that sometimes these visits were shorter than requested and on occasions were as short as five minutes. Within this time care workers said that they had changed one person, "freshened them up", prepared food and drink and had a chat. We did not see how these tasks could have been completed satisfactorily in such a short time which was shorter than had been commissioned by the local authority. The registered provider had failed to ensure that people always received care that was safe and appropriate.

We have commented on similar issues in the safe domain of this report where we have assessed them as in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Services for younger adults may be organised on a different basis so as to produce outcomes for people such as living independently, living safely, etc. This was the way that the group living service was organised by the registered provider. We visited one younger adult who was receiving care from the home care service. We met with their family carer who told us that they were very satisfied with the service provided by the agency. This young adult was allocated the same care worker who used their time flexibly in order to help them pursue activities such as going to the theatre, swimming, and visiting the pub. It was clear from the person's behaviour and attitude that the relationship with the care worker was valued and in turn we were told by their family carer about the intimate knowledge that the care worker had about this person's needs.

We met another young person who was also receiving care from the home care service. They told us that they did not find the service provided was sufficiently flexible to support them in everyday activities in the way they required so as to allow them to participate in activities appropriate to their age. With the permission of the young person we relayed these views to the manager and asked her to make arrangements to contact them to see if these difficulties could be resolved.

Most of the care plans we looked at in the office had been reviewed recently. Some of the people we spoke with also confirmed that their care plans had been reviewed. One person told us "Had meeting last week to go through everything and sort out care – what on which day, who doing what etc. So now all sorted ".

However when we talked with other people they were sometimes unsure how often this took place or even if this had happened at all. They told us "They came out last year to update it (the care plan) and talked to me about it. Involved me fully and made adjustments and used then to bring it back to go through it and check it but never came back so care plan here is not up to date. This one is May 2012. Not had a spot check for over 3 years". A spot check is where a supervisor makes an unannounced visit to observe how staff provide care.

Requires improvement

Is the service responsive?

Some of the people or family carers we spoke with indicated that they had not given, or been asked for feedback in respect of the care and support they were receiving. A number of others said they might have been, but could not remember. Other people told us "Yes, a fortnight ago I was asked if I was happy with the service I was getting. I said I was" and "Yes, some time ago the manager came here and we had a talk. I have always been happy with the help I get and told her so. Another service user said "Yes, a couple of weeks ago. Everything is fine, the manager was very good. I feel I could talk to her if I had a problem".

We asked people if they ever complained about the service they received from the registered provider and if they knew how to do this. People said they knew how to make a complaint. Comments included "Yes I know how to make a complaint but so far, I have never had reason to do so" and ""I do know how to make a complaint and I certainly would do if I really needed to" and "Yes, and I have made one, it was several months ago". One person told us ""I had a carer come to help me. She had a very bad attitude towards me which I found unacceptable. I contacted the manager who dealt with the situation straight away and resolved the problem. I never saw that carer again".

We saw that the registered provider maintained a record of complaints and that six had been received over the last year. Five of these related to the types of concerns expressed to us during this inspection including lack of carer continuity, unpunctuality of calls and carers not staying for the allocated time. We saw that the manager had replied to these promptly and had put in place arrangements to respond to them. One of the people, who lived in one of the group houses told us about how they had been unhappy about something, had complained and it had been resolved.

Not everyone we spoke with felt comfortable about making a complaint. One person told us "I am not a person who complains. I believe if you make a complaint then it can come back on you." Another family member we talked with would not allow us to pass their concerns on to the agency because they said they feared that the service they received might be compromised. Other family members told us they did not feel that their concerns had been properly recognised. This shows that complaints on their own are not a satisfactory means of monitoring the service.

We noticed that the registered provider included a question in their customer survey about the ease with which people could contact the office. This area scored consistently low in terms of people's satisfaction. One relative had commented on there only being an answer phone available with no facility to leave a message. Some people told us that when they rang the office to complain about the service the response was "very reassuring" but that sometimes it did not result in a change or if there was a change it was not sustained.

One person told us that they often had to ring the office to point out that their evening call to help them to bed was being timed to take place earlier than scheduled and earlier than they wished to retire. They told us that each time they complained to the office they were told this would be corrected but each time the pattern of early visits recurred after a short time. They felt that their complaints were ignored. We brought this to the attention of the commissioner who arranged the service on their behalf.

Requires improvement

Is the service well-led?

Our findings

It is a condition of the registration of Always There (Crewe) that there is a registered manager in place. The last registered manager had left in February 2014 and at the time of our inspection no replacement had been registered with the Care Quality Commission (CQC). However we were aware that the current manager had already applied to register and that this was completed soon after our inspection.

Always There (Crewe) is registered with the CQC as part of a company called Always There Homecare Limited. The manager explained that there had previously been two offices, one in Crewe and one in Staffordshire but they had been merged although the two services were still distinguishable by the different uniforms worn by the care staff. The office in Crewe was still named Always There (Crewe) but we became aware that almost all the branded items such as policies and forms bore the name and logo of Carewatch Care Services Limited. We checked the Companies House register and found that Always There Homecare Limited continues to be registered with them as a separate company but at the registered office address of Carewatch Care Services Limited. We found the relationship between the two companies difficult to understand and that some people who used the service were also uncertain of exactly which organisation they were receiving their care from. This might be important if they wished to make a complaint or dispute a matter with Always There (Crewe).

We saw that there was a quality assurance policy which included arrangements to audit or monitor the service. During our inspection the manager made available a number of reports which the registered provider used in this way. These provided information about a number of aspects of performance including carer training, reviews at various key points in a care worker's employment such as after their initial period of employment, supervision and appraisal, field observation checks as well as monitoring key worker requirements such as an up to date Disclosure and Barring Check and proof of driving entitlement and insurance. These were provided for the home care services as well as the group living service.

We saw that there had been an overall upward trend in performance since the current manager had taken up her post. The information provided in these reports together with the detailed records we saw in evidence at the office showed that the manager was able to monitor some trends in respect of certain aspects of the service.

In view of what people had told us about the reliability of visits we asked the manager to show us how she monitored attendance by care workers. We were told that in the Staffordshire area this information was produced by the use of an electronic system which required care workers to "swipe" in and then "swipe" out at the beginning and end of each call. This allowed for both the commissioner and the registered provider to monitor activity. The manager provided us with information relating to the last six months and we saw that this recorded that between 80% and 90% of visits took place in this area within the planned time.

We asked the manager how she monitored the reliability of the service to people who lived in the other areas served by Always There (Crewe). She told us that where the local authorities did not use a computerised system the same information was not available to her. She told us that the main way in which she monitored performance in these circumstances was on the basis of complaints. However we saw that this was not a reliable way of measuring performance because not all of the people who use a home care service were willing to complain. The registered provider had failed to ensure that effective systems were in place to monitor the quality of the service provided.

This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that staff logged their attendance times into a communications book which was kept in each house and we were able to compare some of these entries to the rotas which helped us to build a picture of performance in some instances. We asked one of the commissioning authorities if it held information about missed or late visits and the numbers of carers used to provide care to individuals but they told us they did not have any concerns at present. However we were contacted after the inspection by another local authority who told us that they had concerns about missed calls.

The manager provided us with details of customer satisfaction surveys that had been sent out to people who

Is the service well-led?

used the domiciliary care service by the registered provider. The survey was sent out to a 10% sample of people on a three monthly basis and included 18 questions about different aspects of the registered provider's performance. It also invited people to grade the likelihood they would recommend the service to friends and family as well as inviting them to make suggestions for improvement. The results were then displayed in a table and colour coded so that the manager could identify any areas that required her to take action.

We looked at the results for the last two of these reports which covered October and the previous August. Both showed consistent levels of dissatisfaction around people knowing the identity of the care worker in advance, consistency of care worker or workers between visits and punctuality of care worker visits. Very few respondents reported receiving a visit from a senior member of staff from the agency although the quality assurance policy stated that this should be at six monthly intervals. We saw that there was also some dissatisfaction with the way telephone calls were dealt with at the office.

We asked the manager about these results and the comments we had heard from some of the people we had talked with. She explained that most difficulties were caused when care staff were unexpectedly unable to work for example because of sickness or because their car broke down. In these circumstances the priority was to find another care worker often at very short notice to cover the absent worker's calls. She told us that in these sometimes hectic circumstances it was not uncommon to forget to notify the person who used the service about the change and that as the substitute care workers were juggling the additional calls with their existing rotas, the timing of some visits would inevitably be affected.

The manager also explained that because care staff often had family commitments it was much more difficult to find staff to cover evenings and hence this was one reason why there was greater inconsistency reported at night time and weekends than in the mornings. The manager demonstrated from her knowledge of the service that she was aware of these issues and was taking steps to ensure that where possible they were rectified. For example, she had reminded staff that current practice required that they delivered their visits according to the rota which showed when people wanted care and not at a time that suited the staff. She had experimented with different ways of recruiting and covering more remote locations. The registered provider was introducing new pay arrangements which would include an element for eligible travel between visits. This might aid recruitment and would require staff to keep a record of contact time with people.

When we talked to staff they confirmed that they received supervision and we checked records to confirm that this was the case. One member of staff told us that since the current manager had arrived "Things have changed for the better. Staff are a lot happier". People who used the service also commented favourably on the current manager saying "Yes – I think the manager is good" and "Yes – I think she is very helpful" and "If you ring in and speak to the Manager you get action, she listens to what you say".

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 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 Treatment of disease, disorder or injury	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **The registered provider did not take proper steps to ensure that the planning and delivery of care ensured the welfare and safety of the service user.**

Regulated activity	Regulation
Personal care Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance **The registered provider did not implement effective monitoring systems to protect service users against unsafe care.**