

Supreme Care Services 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?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Requires Improvement 

# Summary of findings

## Overall summary

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. The service provided care and support to older adults, people with disabilities and people living with dementia. At the time of our inspection 301 people were receiving care. The inspection took place on the 4 and 5 July 2018 and was announced.

At our last inspection on 15, 16 and 17 August 2017 we identified six breaches of the regulations around staffing, safe care and treatment, person centred care, safeguarding adults from abuse and good governance. At our current inspection improvements had been made however we still found breaches in safe care and treatment and good governance.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve all the key questions to at least good and to bring them out of special measures.

The service had appointed a new registered manager since the last 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.

The service had recruited new staff which had improved staffing levels however verbal feedback we received highlighted there were still issues around timeliness of visits and missed calls. This meant people were missing mealtimes and their medicines.

The service had improved how they assessed risk by introducing a risk stratification tool which captured important information about people who presented with high risk and management reviewed this on a weekly basis. Risk assessments were now robust and provided information to staff to understand all the different risks people faced and how to mitigate against them. Staff were more vigilant to risks in people's homes.

Staff received updated training in safeguarding and understood their responsibilities to report allegations of abuse to management and whistleblow if needed. The service also acted promptly upon receipt of allegations of abuse and worked with the local authority. Relatives felt confident their family member was safe with staff as they had observed improvements in how staff treated them and comments we received were positive about safety.

Medicines management had improved and the service had amended the medicine administration records (MAR) they used to a format that ensured staff could accurately record the medicines given and avoid errors. However, staff understanding of the different levels of support provided to people was not consistent.

Staff received a comprehensive training programme and service had appointed field supervisors to be leads in particular areas to support care staff.

Care plans had improved and were person centred.

The service followed the principles of the Mental Capacity Act 2005 and people confirmed they were encouraged to make their own decisions and maintain independence.

We received positive feedback in relation to how people were now being treated by staff from the service. Relatives stated that staff cared about their family member and showed respect and compassion. People were forming good relationships with staff and where there had been long standing care arrangements, these working relationships had just become stronger. Staff were responsive to people's changing needs and moods and would raise concerns with the office straight away.

The service had completed work around inclusion in the community and had commenced a quarterly coffee morning with people who used the service. They had also introduced an LGBT inclusion and equality policy to include people who identified as LGBT whether it be staff or people who used the service.

The culture and atmosphere at branch level had improved and staff felt more welcome. Management of the service acknowledged they had to make changes to improve and staff confirmed they could see the changes taking effect. A number of audits were introduced and were being completed in line with the audit schedule. Information from the audits was being used to drive improvement and ensure people were receiving care as they should.

Staff were kept informed around best practice and information was shared with them in a timely manner.

The service sought feedback from people, their relatives and external stakeholders and feedback was overall positive. Improvements were needed when it came to sharing information with people about changes in the branch office.

We found two breaches of the regulations relating to safe care and treatment and good governance. The overall rating is requires improvement and no key question is inadequate therefore the service is no longer in "special measures."

We have made four recommendations.

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 were not receiving care when it was time sensitive in particular when they required their medicines or support with meals.

Medicines management had improved and staff had been trained how to correctly complete the MAR chart.

Risk was managed well and people had comprehensive risk assessments that mitigated against risk.

People were kept safe and staff understood the safeguarding responsibilities.

Recent recruitment was carried out safely.

### Is the service effective?

**Requires Improvement** ●

The service was now effective.

Staff received training in mandatory areas and were commencing specialist training to support them in the role.

Staff received supervision and appraisal and were able to speak to management about their learning and support needs.

Staff followed the principles of the MCA 2005 and people were encouraged to make their own decisions. The service needed to ensure relatives had the correct power of attorney to make decisions about health and welfare.

People had a thorough assessment of needs.

The service worked jointly with external health professionals.

### Is the service caring?

**Good** ●

The service had improved to Good.

People spoke warmly about the carers they received. Staff took the time to get to know the people they supported.

Staff respected people's privacy and dignity.

People appreciated continuity of care however they wanted to be informed when a temporary carer was to attend to them.

The service was an inclusive service and welcomed people and staff who identified as Lesbian, Gay, Bisexual and Transgender.

### Is the service responsive?

Good 

The service was now responsive.

Care plans were now more person centred and detailed. The service involved people and their relatives in the care planning process.

People received regular reviews of their care to ensure it met their needs.

The service offered training in end of life care but did not have any advance care packages.

### Is the service well-led?

Requires Improvement 

The service had improved in well led but good governance was not embedded.

People's preferences around call times were not always respected.

People felt that communication around staff changes at the branch could be better as they were not aware there was a new branch manager. People and their relatives could give feedback about the service and it was listened to.

Staff spoke highly of the improvements that had been made in the new paperwork and level of communication they received. Staff felt the atmosphere and moral at the service had improved.

A number of quality audits had been introduced to check the quality of the service people received and management at the branch were completing them.

The service shared best practice with staff at team meetings and worked with the local authority to share best practice.

# Supreme Care Services Limited

## **Detailed findings**

### Background to this inspection

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

This inspection took place on 4 and 5 July 2018 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is a domiciliary service and we needed to be sure that they would be in.

The inspection was carried out by five inspectors and two experts 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.

We reviewed information we held about the service which included notifications and safeguarding's.

We spoke to 27 people who use the service and their relatives, 11 care staff, the registered manager, branch manager, company secretary, managing director, care coordinator and two field supervisors. Before the inspection we contacted local commissioners from two boroughs for feedback on the service.

We viewed 22 care plans with their associated needs and risk assessments, 10 staff files including their recruitment, training and supervision records. We also reviewed various policies, minutes of meetings, safeguarding records and range of quality monitoring documentation relevant to the management of the service.

# Is the service safe?

## Our findings

At our previous inspection there was a breach of the regulations around the timeliness of visits from staff. This was due to not enough staff being deployed to meet people's needs, concerns that staff were arriving too early or late for people's scheduled call time and staff not staying for the full duration of the call. There were also concerns where only one carer attended for double up calls and people not receiving personal care in a timely manner. At this inspection, staff told us double up calls had improved from the last inspection. Staff explained if a second carer was late they would inform the office and provide as much safe support as they could to people until a second carer arrived.

People gave mixed feedback about the punctuality of staff. One person said, "They come on time, if an issue they call us." Another person said, "I have one carer every day and a carer on the weekend. They arrive on time. They phone me [if running late]" Another person said, "Oh yes they [carer] do come on time, doesn't ever run late." However one person said, "They are rarely on time, and don't let anyone know." Another person said, "They didn't give me my medicine in time or my breakfast, 7am-8 am is my call [and] they were here at 10.30 a.m." Another person said, "Sometimes they mix my time up, my time is 10 a.m. in the morning but they come about 11 a.m. I have to have my stockings on at a certain time." Another person said, "When a carer turned up over an hour early, I was so tired I couldn't let her in, so no one came at all that morning even though I called the office." Another person said, "They came late, my daughter had to give me care, it's not fair."

This meant the inconsistent timings impacted people when they needed time sensitive support.

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

People told us they felt safe with the carers from Supreme Care Services. At our previous inspection in August 2017 this was not the case as people and their relatives were not confident to be left alone with carers. One person said, "I feel 100% safe with them [care staff]." Another person said, "Yes, I have known them for 5 years. She [care staff] is like a sister to me. I like her so much." A relative said, "Oh yes I know he's safe, he goes out with his carer all the time so I know he's safe." Another relative said, "Very safe, very pleased with the carers. Very attentive to him. No concerns leaving him alone with the carers."

During our last inspection in August 2017 we identified a breach of the regulations regarding the safe care and treatment of people. This was due to risk assessments not being comprehensive and staff not understanding the risks people faced or how to mitigate them.

We found the service had improved in this area and people now received a thorough assessment of risk at the commencement of the service. This was reviewed at planned review dates or sooner if needed. Risk assessments included home premises and environment, nutrition and hydration, moving and handling, medication, body maps and mobility. Staff understood risks and actions required to manage these. For example, one staff member talked about the risks related to smoking and how they encouraged the person using the service to use an astray to prevent a fire. Another staff member talked about the risk of using a

hoist when transferring people from one position to another. A member of staff said, "Make sure slings are well positioned to prevent a fall. Involves proper training, always have to be two [care staff], never do it alone." This demonstrated staff knew how to mitigate risks and prevent any harm towards people.

Where people were identified as having a pressure sore or at risk of developing one this information was identified by the service and detailed records were maintained to show the level of treatment provided. Turning charts were maintained and staff were trained in correct wound management by a member of staff who was the lead in this area and through joint working with the district nurse.

The registered manager showed us their risk stratification tool which was updated every Monday by either themselves or the branch manager. The tool was completed for each borough they provided support to and detailed the type of support people needed for example did they live alone, require a double up, at risk of falls, complex needs, bed sore, diabetes, dementia and reduced mobility. This tool helped the service monitor who was at risk and to ensure their health did not deteriorate further as they were being monitored more closely.

At the last inspection there were also concerns around the safe care and treatment of people relating to medicines management and guidance. During this inspection we found medicines management had improved. People had detailed medicine risk assessments and care files contained guidance for staff about each of the medicines with associated side effects. The service kept in contact with people's GP to ensure they were aware of any changes to medicines and staff were instructed to inform the office if any medicine had changed so that the risk assessment could be updated. Staff completed medicines training which included how to complete the new MAR chart with a competency test. A member of staff said, "I know what to do now, how to fill it [MAR]." Staff understanding of the level of medicine support provided differed. The registered manager explained they offered two levels of support to people if they were not self-administering which were assisting or administering. Staff were maintaining new medicine administration records which had been introduced to minimise the risk of medicine errors. We saw evidence of where a person had refused to take their medicine this was recorded on the reverse of the MAR by the member of staff and the correct number of medicines taken had been recorded.

During our last inspection in August 2017 there was a breach of the regulations in relation to safeguarding people at the service. People were now protected from the risks of abuse as staff could tell us the different types of abuse and explain how they would identify if they thought someone was at risk. Staff at the service received safeguarding training and on-going refresher training. Staff gave examples on what may be safeguarding and what would be reported to their manager such as bruising, people not having enough money, person feeling down or moody and generally not feeling themselves. One member of staff said, "It's our duty to make sure that the abuse is being stopped." Staff told us they were encouraged to report any concerns to senior management and they felt confident that action would be taken. Staff also knew where to take their concerns if they felt management at the service were not taking appropriate action as they told us they would approach social services, the police and the Care Quality Commission (CQC.)

The provider showed us their safeguarding policy and information for staff which included how to raise safeguarding in the different boroughs where support was provided and a 24-hour safeguarding line staff could use. The registered manager showed us their improved documentation to confirm they now audited their safeguarding to include a 'lessons learnt' section and how this information was shared with all staff at the service via team meetings and email broadcasts.

We reviewed the recruitment records of staff who had joined the service since our last inspection in August 2017. Records showed the service sought references from previous employers and completed checks on



people's criminal records to ensure they were suitable to work in a care setting. We noted that some staff had not supplied a reference from their current or most recent employer which was against the provider's recruitment policy. However, this had improved in the more recent files where staff had provided appropriate referees. Staff completed application forms which included information about their employment history. We noted that where people had gaps in their employment history, this had not been explored. There was no record in the interview that people had been asked to explain periods where there was no employment history. Interview records showed potential care workers were interviewed and their experience, motivation and values base for working in care were explored. Although the interviewer recorded applicant's responses to their questions, there was no recorded assessment of their answers so it was not clear how the decisions to recruit were made. A staff member who completed interviews told us they sought approval from their manager before offering a position to a care worker, however this was not recorded.

We recommend the service seeks advice and guidance about safe recruitment.

Staff completed training in infection control and gave examples of how they put this into practice. For example, when providing personal care or preparing food, colour coded aprons were used. This reduced the risk of cross contamination. Staff told us they received sufficient amounts of personal protective equipment (PPE) which also included gloves and masks. People using the service confirmed staff wore protective clothing while they received support.

Staff knew how to report incidents and accidents and told us the procedure they followed. Staff told us that there was an out of hours on call service operated from the office. For example, one staff member told us they had to call an ambulance after a person using the service who was deaf and lived alone failed to respond following a fall. In this instance the staff member explained their priority was to call the emergency services, including the Police who attended and gained access. The member of staff then contacted the office to report the incident to senior staff, completed an incident form and recorded what had happened in the daily records.

## Is the service effective?

### Our findings

At our previous inspection we found a breach of the regulations due to staff not being provided with adequate training to meet people's needs. We found this had now improved.

Records confirmed that all staff were now included in the training program and had completed mandatory training and refresher training to support them in their roles. Staff told us the training provided them with the skills and knowledge needed to give effective care. Mandatory training covered the following areas such as; equality and diversity, privacy and dignity, fluids and nutrition, mental health, dementia and learning disabilities, basic life support, safeguarding, moving and handling and conflict resolution (complaints). We saw from a training matrix that other specialist training, such as managing behaviours that challenged the service, understanding percutaneous endoscopic gastrostomy (PEG) a surgical procedure for placing a feeding tube for people who are unable to swallow, palliative care/bereavement, understanding diabetes, epilepsy awareness and pressure ulcer care were listed as optional training. The registered manager told us that they planned to introduce this training gradually, starting with pressure ulcer care and dementia awareness which staff had completed. Further training in other specialist areas was yet to be completed by staff. Staff completed the Care Certificate which included 15 core standards of care to support staff who look after people in the care sector.

Staff told us that they received regular supervision and a yearly appraisal which they found helpful due to the "one to one" nature. Records confirmed that most staff received regular supervision and where relevant an appraisal. Staff told us that they felt supported by senior management and this had helped them to discuss any concerns or personal development needs, including training. Staff commented, "They call to know if your satisfied with a client" and "If something happens they [manager] call supervision."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The authorisation procedures for domiciliary agencies must be made to the Court of Protection.

Staff supported people to make their own decisions about their care to enable people's independence. Mental capacity assessments were performed to show decisions people may need support with and showed people were able to make certain day to day decisions, such as telling staff what they would like to drink or wear. The service had a poster detailing the five principles of the MCA to help staff understand their responsibilities. Staff worked within the principles of the MCA and offered people choices to help them make their own decisions and held best interest meetings where needed. A member of staff said, "Don't assume someone is not capable." This supported people to achieve good outcomes and helped them maintain their independence.

Staff would ask people for their consent before delivering care and relatives confirmed staff did this. One person said, "They always ask my permission like with shower and washing me". A member of staff told us, "We need to ask before [giving personal care]. Another member of staff said, "Always ask for their consent first. Would you like me to wash you?"

Where people lacked capacity, it was documented who could make decisions on their behalf. However, in two files we viewed we noted where a next of kin had power of attorney for finances they did not have power of attorney for health and welfare decisions. We raised this with a field supervisor who contacted the next of kin to confirm they had applied for the correct power of attorney.

We recommend the service seeks advice and guidance from a reputable source to ensure they are working within the requirements of the MCA

People's cultural choices of food and drink was respected and documented in their care plan. Problems arose where staff were late or did not arrive for people's call which put people at risk of poor nutrition and dehydration.

People had care plans that assessed their needs with important information highlighted in red such as allergies. Care plans clearly stated what people were able to do for themselves and where they needed support for example a care plan said, "I can do all my housework, laundry and shopping. I like my own independence and would like carers to encourage my independence" and "I need one carer to support me with my hygiene".

People's health conditions were in care plans and the service provided risk management sheets where people had particular health conditions to help care staff understand them. For example, we saw a hypertension risk management sheet that gave the signs and symptoms to look out for if someone at the service became unwell which included headaches, fatigue, dizziness, blurring of vision, and facial flushing. Staff helped people maintain good health and kept the office updated by being vigilant to people's health while visiting. A member of staff said, "Sometimes the client's health can change so we come and tell the office."

The service worked with external health professionals such as the district nurse and records showed the service contacted people's GP to remind them to perform an annual health check and provide people with relevant vaccinations which included the flu jab. The service also wrote to pharmacists to try and work together in preparing MAR charts to help reduce the risk of medicine errors.

# Is the service caring?

## Our findings

At our previous inspection in August 2017 people told us not all staff were forming good relationships with them and people told us they did not feel they were treated with respect by staff.

The service had undergone a period of transformation where some care staff had remained and new staff were recruited who believed in the values of providing good care. Feedback from our current inspection had improved with more people saying they had built caring relationships with staff. One person said, "This carer who comes is brilliant, he goes over and above and helps me with my shower. I used to have problems before with Supreme but not anymore." Another person said, "I can't say anything that isn't good" and "I'd be lost without my carers."

Relatives now spoke positively about the staff. One relative said, "The carer who comes now is very respectful and caring. He's [staff] very friendly and listens to my [family member]." Another relative said, "Very much [caring]. They have a great relationship. Even when they are not working they will ring and see how he is. They are very close. We couldn't be more blessed with the carers we have."

A field supervisor told us since the last inspection they were more "hands on" with people and had much more contact. A field supervisor said, "We have new staff with a new attitude, with a willingness to help service users."

As one of the improvements, Supreme Care Services introduced checks to people using the service to find out if the carers were a 'good fit' for them and to see how the service was performing. This gave people the opportunity to give feedback on the quality of the carers and to say if they were being treated in a kind manner. We also observed in the branch posters where there were quotes for staff to remind them to show empathy and to treat people with kindness. For example, staff were encouraged to find out something new about the person they supported and to put themselves in the persons shoes.

Staff could tell us people's preferences and gave us detailed examples on people's routines which demonstrated they got to know what people liked and did not like. For example, a member of staff said, "I support [Person] to the table for dinner, at the end of the night [person] likes it when I leave the light on before I leave."

People felt that staff spent the time needed to support them and getting to know them and information was given in care plans about what mattered to them. Staff were also vigilant to changes in peoples' emotions and moods and suggested resolutions to help them. For example, a member of staff said, "I'm the only contact a service user has with the outside world, it is imperative to know what they need." The same member of staff gave an example of how they realised someone they supported was not accessing the community enough and suggested time at the community centre. This was raised with the coordinator and the person was able to have their time increased to visit the centre. This demonstrated the staff's awareness to prevent social exclusion and isolation which ultimately made the person feel uplifted as described by the member of staff. Records confirmed this.

One person said, "They [staff] do everything for me, even take my washing down to the laundry room if I ask."

People's dignity, privacy and diversity was respected. The service had appointed a dignity champion who was a member of staff who promoted how to display the qualities to ensure people's dignity. For example we saw information in people's care plan about their wishes regarding staff either to remove their shoes wear shoe covers when entering some people's home this meant staff were aware to respect people's wishes.

The field supervisors at the service ensured staff were showing people respect through supervising them. People's choice of carer was also respected. The field supervisor said, "We make sure we get the right carer, we try and meet their needs." This included meeting people's choices to have a carer who understood their cultural needs.

Staff explained how they ensured people's privacy and dignity was protected. A member of staff said, "I always close the door and curtains and use a towel to cover [person]." The same member of staff told us how other staff and district nurses would also respect people's dignity by knocking on doors before entering when personal care was being given.

The service had undertaken work to support people and staff who identify as Lesbian, Gay, Bi- Sexual or Transgender (LGBT). The service had an LGBT inclusion and equality policy which covered fair recruitment and drawing experience from existing LGBT staff. Also protecting and including people who used the service by tailoring the service provided to meet people's preferences and maintaining confidentiality around sensitive information. A member of staff said, "We used to have someone who identified as LGBT. We have no problems with working with LGBT people. We will provide the service." Care plans had not included information about whether people identified as LGBT or their relationship status. We raised this with the registered manager who advised the care plan would be updated to reflect this.

Care staff understood the need for continuity of care and this was reflected in the feedback from people who used the service and their relatives. Where people had the same carer, they could form bonds and they did not have to explain themselves all the time. Some people and their relatives explained when staff went on annual leave the continuity broke down. One relative said, "The carer told us they were going on leave but the company didn't tell us who we would be getting." This left people feeling frustrated.

We recommend the service seeks advice and guidance around continuity of care.

## Is the service responsive?

### Our findings

During our last inspection we found a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in relation to the assessment of people's needs and level of detail for their support. Care plans had improved and showed the service discussed and documented people's preferences with them and their family if they wished. The service employed field supervisors who were responsible for assessments and reviews within assigned postcodes in the borough. The registered manager explained this was done with the aim of helping staff build relationships with people and their relatives as they were linked with that area. One person said, "Yes they [field supervisor] did come and sit with me and asked me what I wanted". A relative said, I believe he has a care plan. They [field supervisor] sat with uncle and went through and asked what he required".

Staff told us care plans had improved due them having more information in them and really helped to get to know people. Staff also told us they read the care plan and people we spoke to told us they saw staff do this when they visited. One member of staff said, "They are really helpful and I read it thoroughly to update myself". Staff also told us if there were any discrepancies around the type of care or omissions in the care plan they would inform the office for it to be updated.

Records confirmed people received care plan reviews at the correct date and people told us that they were visited by field supervisors to discuss whether they were happy with their care package.

Each care plan was written in the first person and stated how people wanted each aspect of their care to be provided in accordance to their preferences. In an example where breakfast support was given, one person's care plan said, "I like to eat two pieces of bread with butter and an anchovy slice along with black coffee and no sugar". This helped staff get to know people and know exactly how people liked things to be done for them.

One of the first documents viewed in the care plans was an "all about me" cloud which included preferred wake up and bedtimes, favourite drinks, activities and types of clothing people liked to wear. The service had also introduced an outcome star which was a tool to encourage people to be independent.

Another care plan gave very clear instructions on the support to give someone when delivering personal care, the number of staff involved and what the staff should be doing, for example, "Carer one should hold me and carer two should assist with my undressing." Care plans made clear the type of toiletry products people liked to use, where medicinal creams were used and how they should be applied.

The service had introduced a quarterly coffee morning to improve community engagement and prevent social isolation. We saw photographs confirming this had taken place and people were engaging with all staff from the service. Feedback from people included the service had really turned around and there was one person who had now decided to stay with the service as they had seen improvement.

People we spoke to told us they have and knew how to raise a complaint. The service had a complaints

policy which told people where to send their complaints and how long it would take to receive a response. The service responded to complaints in line with their policy, records confirmed this. People still raised concerns regarding their ability to speak to someone on the out of hours telephone line. One person said, "I can never get through to the out of hours number or leave a message".

We recommend the service follow best practice around communication access during out of hours.

The service did not have any advance care packages where people were approaching the end of life. Training in end of life was part of the services scheduled training program.

## Is the service well-led?

### Our findings

At our last inspection we found a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to governance issues. At that time the service did not have effective quality monitoring to ensure people received safe and quality care.

The provider had introduced new technological systems to improve call monitoring compliance by staff. However, call monitoring still needed to improve. We reviewed the call monitoring information from ten staff who were using electronic log in systems to record their visits of care. These records showed that while people were receiving the amount of care scheduled, they were rarely receiving care on time. For example, one care worker was within fifteen minutes of the scheduled time only 35% of the time. Another care worker was within fifteen minutes of the schedule time only 23% of the time. Some care worker schedules were impossible to complete as they were given no travel time, or scheduled simultaneous visits. The coordinator told us the simultaneous visits only occurred when care workers took on additional cover when other care workers were not available.

The service audited their telephone logging system for late and missed calls. This audit did show the service were aware of the issues around certain staff not arriving at people's calls when they should and the action they were taking to improve this through either supervision with them or to confirm with people their preferred arrival time.

After the inspection further records were sent which showed the provider monitored the attendance of care workers and made calls to them if they noted they were arriving at calls late or early. When care workers reported to the provider whether they were running late due to an overrunning call, the provider contacted people and their relatives to inform them the care worker would be late. Records showed care workers also often reported that people had requested a change in their visit times directed with them. It was not always clear the provider verified this with people themselves. We saw that calls to people and their relatives to confirm changes to call times took place on less than half of the changed visit times. This meant it was not clear the changes in times were always at the request of people receiving a service and meant that people were not receiving safe care at times as they missed medication and mealtimes. The provider acknowledged they needed to review the information they held about people's preferred visit times as this had last been completed six months ago and was now out of date.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

During this inspection the service had put in place a number of additional systems to monitor, manage and improve the quality of the service. The registered manager showed us records of their internal audit schedule and who had oversight of those at the branch. Within each of the audits there was the aim to identify what had not worked and to ensure that staff were informed so that it did not occur again. The service also had a business strategy for improvement. A quarterly service user records audit highlighted where information in people's records was missing and the registered manager could easily identify where a



field supervisor had not updated the information by the specified deadline and inform them of this. To satisfy the registered manager the field supervisors had to produce evidence they had completed the work. The registered manager informed us that where field supervisors had repeated non – compliance in their recordkeeping they were to be retrained to the minimum requirements. This ensured people's documentation was up to date and held correct information. Daily logs were now being collected monthly and audited for content and legibility. MAR charts were audited monthly by the branch manager to check they had been completed correctly and that people were receiving their medicine at the correct times.

The management of the service at branch level had changed with the appointment of a new branch manager and a new registered manager. The service had appointed field supervisors who performed assessments and had a lead role function in an area of expertise which included medicines, dignity and respect, falls and dementia and pressure care. This meant that the branch supported staff learning and development.

Staff commented on the management being very supportive, approachable and visible and the registered manager told us they were supported by senior management. Staff felt the service was now well run and could see the changes were taking effect. One member of staff said, "Since [registered manager] came, she knows how to talk to people in a very calm way, and she knows the job, I'm very satisfied."

Feedback from the local authority meant they partially lifted the suspension on the service accepting new packages. A commissioner told us they could see improvements in the staffing structure particularly posts with management responsibilities.

People and their relatives gave mixed feedback about the running of the service but the majority was positive. People liked the field supervisors Where it was negative it related to previous communications they had experienced at office level. People we spoke with were not always sure who the manager of the service was and some did not know there was a branch manager but the registered manager showed us records to confirm they had sent a letter introducing the changes in management structure. The registered manager told us they would send an updated letter to advise of the changes at branch level.

The registered manager was aware that staff morale was low previously and worked with senior management to find out how it could be improved to make sure staff worked towards the same goal of providing quality care. The service met with their staff to ask what had happened and gone wrong. The feedback management received meant staff were then given the right training and support to carry out their role with two new trainers introduced to the service, staff were told when they were doing a good job to boost confidence in addition to the introduction of recognising a "carer of the month". Staff felt this improved staff morale and the culture at the branch. A member of staff said, "The atmosphere is better, I was scared to come in before (to office)."

The registered manager explained since the last inspection and due to the improvements made they had worked with the local authority to share best practice. Best practice was also discussed during team meetings. The registered manager was aware of their duty to report and share information quickly with external agencies and the CQC through statutory notifications and safeguarding information.

Spot checks continued to take place either by visiting people or via telephone and the process was more robust as the field supervisors asked people more questions about the quality of the care, if it was given in accordance with their care plan and if people felt respected by staff.

The registered manager showed us their scheduled team meetings with care staff and with office staff and

minutes from these meetings showed that the service discussed clinical governance, people using the service, risk management, risk stratification, business updates, CQC updates and care staff including their compliance and supervisions. Where staff could not attend meetings, they would be sent a copy of the minutes either by email or text message to their work mobile provided by the service. One member of staff said, "We are going through a transformation we have moved a long way. We haven't got there yet but progress at each step." The same person said, "Better communication with staff."

The service sought feedback from telephone monitoring, spot checks and questionnaires from their staff, people who used the service and their relatives and external stakeholders. Comments included, "I'm happy", "Care workers [are an] asset to supreme", "[Staff] does a fantastic job" and "[Staff] is patient and humble."

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  Care and treatment was not always provided in a safe way. 12 (1) (2) (a)
Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance  The registered person must improve the quality and safety of services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). 17 (1) (2) (a)