Carewatch Care Services Limited

Carewatch (Morecambe)

Inspection report

The Lighthouse Care Centre
1 Townley Street
Morecambe
Lancashire
LA4 5JQ

Tel: 01524402340
Website: www.carewatch.co.uk

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09 June 2017

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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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection visit at Carewatch (North) took place on 31 May, 02 and 09 June 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service to people living in the community. We needed to be sure someone would be in at the office. Carewatch (North) registered as a domiciliary care agency with the Care Quality Commission in January 2016. We had not previously inspected the service.

Carewatch (North) provides personal care and support to people living in their own homes. The agency covers a wide range of dependency needs including older people with a physical or learning disability and older people living with dementia or mental health problems. The agency's office is located close to Morecambe town centre. At the time of our inspection there were 403 people receiving a service from Carewatch (North).

The service had a registered manager in place. 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.

At this inspection visit carried out in May and June 2017, we found breaches in the regulations relating to Safe care and treatment, Good governance, Staffing and Fit and proper persons employed.

We looked at how Carewatch (North) managed risk. We were informed that moving and handling procedures had not followed identified risk management plans. This meant the registered provider failed to follow processes that protected the safety and welfare of people and staff.

We looked at the administration of medicines and creams. Documentation did not guide staff on the proper and safe management of medicines and creams.

We looked at how Carewatch (North) recruited staff. We found recruitment policies were not followed to ensure staff were of good character and be able by reason of their health to perform their role.

We looked at recordkeeping and auditing. We found robust systems were not in place to assess the service consistently to deliver and drive improvement.

We looked at care plans and found the registered provider had failed to provide every person with a clear treatment plan. Not all people had documentation in their home to guide staff.

We looked at staff training. There was a structured induction and ongoing training plan in place. Staff told us they had received safeguarding adults from abuse training. They told us they knew how to recognise signs of abuse and who to alert. However, the registered provider failed to provide learning and development

opportunities to develop necessary skills to meet the needs of the people they care for and support.

We have made a recommendation about the use of language that promotes respect and protects people's dignity.

We have made a recommendation about positive communication and leadership.

People and their representatives told us they were involved in their care and had discussed and consented to their care. We found staff had an understanding of the Mental Capacity Act 2005 (MCA).

We found people had the opportunity to have support to access to healthcare professionals.
People made positive comments about the staff including their attitude and respectful manners. Staff showed an awareness of promoting people's rights to privacy, dignity and independence.

End of life care was available, flexible and tailored around the needs of the people who required the support.

Where appropriate, people were supported to sufficient to eat and drink and maintain a balanced diet.

Consultation had taken place with people and care plans were reviewed.

Staff were given support and the opportunity through supervision and staff meetings to give feedback on their role and experiences.

You can see what action we have asked the registered provider to take at the back of the main body 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.

Staff had been trained in safeguarding and were knowledgeable about the ways to recognise abuse and how to report it.

Risks to individuals were identified. Guidelines to manage the risk were not consistently followed.

Recruitment procedures the service had in place were not consistently followed.

Medicine documentation did not clearly guide staff on the administration of medicines and creams.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had received a structured induction training related to their role.

The registered manager and staff were aware of the Mental Capacity Act 2005 (MCA) and had knowledge of the process to follow.

The registered provider did not provide specialised learning and development to meet the needs of the people they cared and supported.

When required, people were supported to maintain a balanced diet to prevent the risk of malnutrition and dehydration.

Where appropriate the registered provider worked with healthcare professionals to provide care and support.

Is the service caring?

Good

The service was caring.

Language used by staff did not always promote and protect people's dignity.

Most people who used the service told us they were treated with kindness and compassion in their day-to-day care by staff.

Staff had developed positive, caring relationships and spoke about those they visited in a warm, compassionate manner.

People were involved in making decisions about their care and the support they received.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Not everyone had a care plan to guide staff on people's support needs.

People told us they contributed to the assessment of their care needs and consented to the planned outcomes.

The registered provider had a formal complaints policy and procedure.

Is the service well-led?

Requires Improvement

The service was not well-led.

Quality monitoring arrangements were not robust and did not ensure a quality service was delivered.

Feedback on the management team was conflicting. We received very negative and extremely positive views on the management of the service.

There were regular team meetings for staff to attend.

The service had clear lines of responsibility and accountability with a structured management team in place.

Carewatch (Morecambe)

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.

One adult social care inspector and one expert by experience carried out the inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience who took part in this inspection had experience of caring for older people.

Prior to this inspection, we reviewed all the information we held about the service, including data about safeguarding and statutory notifications. Statutory notifications are submitted to the Care Quality Commission and tell us about important events that the provider is required to send us.
We spoke with the local authority to gain their feedback about the care people received. This helped us to gain a balanced overview of what people experienced accessing the service. At the time of our inspection there were no safeguarding concerns being investigated by the local authority.

We visited four people who received support in their home with their permission and looked at their care plan and medicine records. We spoke with eight people who used the service and five relatives via the telephone. We spoke with the registered manager, acting manager and 12 staff members. We reviewed 17 people's care records, eight staff files, the staff training matrix and a selection of policies and procedures. We reviewed records related to the management and safety of the service.

We looked at what quality audit tools and data management systems the registered provider had in place. We reviewed past and present staff rotas focussing on how staff provided care within a geographical area. We looked at how many visits a staff member was completing per day. We looked at the continuity of support people received.

Requires Improvement

Is the service safe?

Our findings

As part of this inspection process, we visited and telephoned people to gather their views on the service they received. We asked people if the care they received made them feel safe. One person told us, "Safe? Yes it seems ok I trust them. I take my tablets and they check it." A second person commented, "When they come they know how I like my door fastening. I have an intercom they ring the bell and I can see their picture. They have a key safe." A relative said, "[Relative] is safe, very safe." A staff member said, "I wouldn't leave anyone unsafe."

We looked at care plans to see how the service provider managed risk. We found care plans identified hazards and risks. However, the safeguards put in place were not always followed. For example, people who were identified as requiring two staff members to manoeuvre them using a hoist, had been moved by one staff member. We spoke with a member of staff about this, and they told us they had refused to follow these instructions as it was against the training they had received.

We spoke with a member of office staff responsible for rotas about one staff member completing moving and handling procedures when two staff are required to keep people safe. They told us it had happened due to being short staffed. They commented, "It happens, it shouldn't happen but you can't knit a carer when you want one." Two relatives we spoke with told us they helped with moving and handling their family members when only one staff visited. One relative commented, "I just stand on the other side, that doesn't happen very often." A second relative said, "I have helped in the past." Both relatives had not received any training related to moving and handling. One person who used a hoist told us, "It did occur due to the lack of staff."

We spoke with the registered manager who told us they would never expect one staff member to complete a task where two staff were required. We spoke with the acting manager who told us they were aware single person moving and handling had occurred but it was no longer happening. They told us there had been a recruitment drive to ensure staffing levels were appropriate. We were made aware there was an internal investigation taking place at the time of our inspection. They had received information of concern from a staff member on the subject and were in the process of gathering evidence. This showed the service had systems in place to investigate any concerns raised and keep people safe.

Also related to managing risk, one person was identified as having type one diabetes. Treatment aims to keep blood glucose levels as normal as possible and control symptoms to prevent health problems developing. There were no guidelines or risk assessment to monitor and manage the condition safely. A second person's guidelines had the instruction, 'monitor pressure areas.' Again, this did not identify where the area was or guide staff what to look for. This meant people were at risk of exposure to unsafe care and support. We shared our findings with the registered manager and acting manager who stated they would review all care plans.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). The registered provider failed to adopt control measures that minimised the

risk for people using the service and staff.

We spoke with people to see if their medicines were managed safely. We also looked at relevant documentation to see if professional guidance was being followed. We received mixed feedback from people. One person told us, "They do my medications and chart it." When we visited one person and asked if they get their medicines they told us they did. We shared concerns that the medicine administration record (MAR) was not signed on two occasions. They commented, "They [staff] should do, they are not brilliant at that."

As well as the two missed signatures on different days. We read one dose of tablets were not administered but left on the table for the person to take later unsupervised. The staff member had signed to indicate the medicines had been administered. The staff member on the following visit found and administered the medicines. They had documented the error but no action had been taken.

We also noted the person had not received a medicine for four days. The medicine was used to treat the symptoms of dementia in people diagnosed as having mild to moderately severe Alzheimer's disease. It was documented on two consecutive days, 'ran out informed management', 'due tomorrow', and 'still haven't come'. There was no on call record related to the lack of medicines. We spoke with the acting manager who told us they would investigate the incident.

We looked at one person's schedule of visits. It was identified in their care plan, 'Client has [named illness] and needs prompting to eat and take medication.' We noted a three hour gap between two daily visits. With the flexibility or tolerance built into visits it could be two hours between visits. We asked if it was safe for staff to prompt the administration of medicines in so short a period. The acting manager was unsure. There was no documentation to show the impact, if any, on the person who received the medicine. They sought medical guidance and took appropriate action during our inspection.

One person's guidelines instructed staff to, 'please cream my pressure area.' They failed to instruct staff where the pressure area was. This left the person at risk of receiving support that did not meet their care needs as staff may not be aware of what areas to treat.

This was a breach of Regulation 12 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Safe care and treatment). The registered provider failed to ensure sufficient medicines were available. Documentation did not guide staff on the proper and safe management of medicines and creams.

We looked at recruitment records of 10 staff. All required checks had been completed prior to any staff commencing work at the service. Recruitment records looked at contained a Disclosure and Barring Service check (DBS). These checks included information about any criminal convictions recorded, an application form that required a full employment history with any gaps explained and references from previous employers. These checks were required to ensure new staff were suitable for the role for which they had been employed.

Records for two staff members showed they had criminal convictions. We saw the registered provider had completed an appropriate assessment to manage any potential risks. However, one staff member had received a reference stating they would not be suitable for the role. There was no documentary evidence to show the registered provider had investigated with the person the negative reference or sought supplementary evidence they were of good character. A second prospective staff member had a history of mental illness and one reference stated, 'needs a lot of focus.' Again, there was no evidence to show whether the person's personal circumstances had been explored, and whether any reasonable adjustments in the

workplace would be needed. A third prospective staff member had submitted two references, one from a close family member and the second from a friend. There was no evidence that these references had been discussed or additional references sought. We spoke with the acting manager who told us they would review recruitment procedures and investigate the concerns we raised to ensure people were safe.

This was a breach of Regulation 19 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Fit and proper persons employed). The registered provider failed to follow effective recruitment and selection procedures.

We looked at how the service was staffed. We reviewed past and present staff rotas and focused on how staff provided care within a geographical area. We looked at how many visits a staff member had completed per day. We did this to make sure there were enough staff on duty at all times to support people in their care. People we spoke with gave mixed feedback on the continuity of staff. One person told us, "They seem short of staff, they need more." A second person commented, "I get a bit fed up of different faces." The acting manager told us they had recruited staff to work in the geographical area where people had raised concerns.

We spoke with the registered manager who told us they planned visits around geographical locations. Staff we spoke with confirmed they had visits within a geographical area. Rotas we looked at for staff who drive and staff who walk to and from visits showed they had time to travel between clients.

The registered provider operated an on call service to protect staff safety and keep people safe, when staff were lone working or working unsocial hours. One staff member told us, "If I have any questions. I ring [supervisor] for the answer. They are brilliant." They further commented, "When I ring on call they always ring back within five minutes." This meant, should it be required, staff could contact a member of the management team for guidance and support.

During the inspection, records we looked at contained information that the management team and staff had received abuse training. There were procedures in place to enable staff to raise an alert. Staff demonstrated a good understanding of safeguarding people from abuse, how to raise an alert and to whom. Care staff said they would not hesitate to use this if they had any issues or concerns about care practices or conduct. One staff member stated, "I am here to work to keep people safe. They deserve the best care." This meant the registered provider had systems to guide staff about protecting people from potential harm or abuse.

Requires Improvement

Is the service effective?

Our findings

We looked at how Carewatch (North) trained and supported their staff. We asked people who used the service for their views on staff abilities. We asked staff who received training for their views. One person said, "They don't seem to be able to keep staff but the ones who do come in are excellent". A second person commented, "They [staff] do a job and they do it well". A third person told us, "I have confidence in them."

However, a relative said, "It varies how well they are trained we had one that was excellent. We had one particular girl who was good at everything you could tell she loved her job". A second relative said, "They know what they are doing, they are well trained, we are never forgotten about, they let us know if there's any problems and if they are going to be late and why".

We spoke with staff members, looked at individual training records and the services training matrix. Staff told us the training they received was provided at a good level. Carewatch had a central training team and all training was delivered at the office base. There was an initial four-day induction followed by day five within the following twelve weeks. During our inspection visit, we joined day five of induction training and spoke with staff. One staff member said regarding induction training, "The trainer is really good I can relate to him." A second staff member told us, "I found the training informative." A third staff member told us as part of their initial training they shadowed a member of staff. About this, they told us, "I shadowed [carer] she's an expert and talked me through different situations."

The registered manager told us staff had to complete a workbook prior to their induction training. They also have the opportunity to meet the trainer before the course. The registered manager also stated they had been sitting in on training to assess its validity.

Regarding ongoing training a staff member said, "The training is regular. [Trainer] he's nice, we all like him." A second staff member told how pleased they were having achieved 100% in an exam. The test was to assess their competency and contributed to the vocational qualification they were working towards. About the training they received they commented, "Training in groups is good, we listen to each other and bounce ideas of each other."

Records seen confirmed staff training covered a range of subjects including safeguarding, moving and handling, first aid and food hygiene. However, we noted people being supported had complex needs. We asked about specialised training. One person received their nutrients through a tube that went into the stomach. Guidelines stated, 'peg feed only, this is to be done by carers.' We asked about training for staff. We spoke with four members of the management team on the subject. We were informed; some staff had certificates in their folders to show they had been trained. They were unsure which staff and when the training had occurred. There was no regular training on the subject. The registered manager told us they would speak with the community-based nurses regarding introducing the training.

One person wore compression stockings. These are specially designed to apply pressure to the lower legs and help maintain blood flow and reduce discomfort and swelling. We asked about training for staff on the

application of the stockings. There was no training and no record of who had shadowed and witnessed the stocking being applied. The acting manager told us they had received training and was able to, and would arrange, carer training to meet this need.

This was a breach of Regulation 18 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Staffing). The registered provider failed to provide learning and development opportunities to maintain necessary skills to meet the needs of the people they care for and support.

Records seen and staff spoken with confirmed staff received regular supervision. These are one to one meetings held on a formal basis with their line manager. Staff told us they could discuss their development, training needs and their thoughts on improving the service. They told us they were also given feedback about their performance. One staff member told us, "I have my appraisal with [member of management team], it is good." Every staff member spoken with praised the quality officers and co-ordinators on the support given. "I can go to them with anything", "They sort out my problems" and "They always get back to me". This showed staff received effective support to carry out their role.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. Policies and procedures were in place in relation to the MCA. Staff files showed they had received training related to the MCA and the principles of consent.

People we spoke with all stated that staff offered choices and waited for their consent before proceeding with tasks. One person told us, "We are fully involved and the carers are excellent".

When required, people were supported to maintain a balanced diet to prevent the risk of malnutrition and dehydration. For example, care plans seen confirmed people's dietary needs had been assessed and any support they required with their meals documented. Staff members completed food preparation at mealtimes with the assistance of people they supported where appropriate. We visited one person who had been supported with the preparation of their lunch. The staff member had prepared a sandwich for their tea that had been left on the agreed shelf, on the agreed side of the fridge. We visited a second person and there were several drinks within reach. The staff member we accompanied to the visit knew the persons preferred drink and discussed "drinking plenty" in the hot weather. Staff spoken with confirmed they had received training in food safety, nutrition and hydration and were aware of safe food handling practices. This showed the registered provider had a system that protected people from risks related to dehydration and malnutrition.

The registered provider was working with other health care services to meet people's health needs. Care records contained information about the individual's ongoing care requirements. We saw healthcare referrals had been made to support people to maintain good health. However, most people were able to access services independently or with the help of a family member.

Good

Is the service caring?

Our findings

We asked people about the care and support they received from staff employed by Carewatch (North). We wanted to know if people had had positive caring experiences and were treated with kindness.

One person told us about their carers, "Very kind caring and compassionate. When I'm having a wash they keep me covered". A second person said, "The staff are hardworking, thoughtful and kind. We have made friends, they are lovely." A relative commented, "They are caring kind and compassionate on the whole and respect [relatives] privacy and dignity".

However, one person told they had a bad experience with one staff member. They stated, "She was very, very rude. I only met her once and I don't want to meet her again." We asked if they had shared their concerns with a member of the management team. They told us they had and the person had not visited again. A second person also expressed concerns on the same staff member. The registered manager told us they would investigate the concerns and take the appropriate action.

As a company, Carewatch has pledged to use positive words around dementia. They have sought to educate people around the importance of choosing words carefully. However, in the care plans we reviewed we noted 'cot sides' were referenced. There were also guidelines around feeding people, for example 'feed lunch.' The language we use can influence how staff treat or view people who require support and may be vulnerable.

We recommend the service review all documentation to ensure people's dignity is respected and upheld.

We visited one person who spoke very fondly of a regular carer. In the lounge, there was a small white board the carer used to leave messages on. This was part of an ongoing interaction between the person and the carer. The last message left by the carer was, 'Caring for our seniors is the greatest responsibility we have. Those who walked before us have given so much and made possible the life we all enjoy. Keep smiling.' It was apparent the carer spent time with the person and a positive relationship had developed.

One person told us staff made sure they were happy and content. For example, they said, "I have hot water plants, brownie green in colour with purple flowers on. My carers water them for me. I get pleasure from my plants. They do a good job they do it well".

Staff spoke fondly of the people they supported. One staff member said, "The people I care for are like family. I go above and beyond because they deserve it." They told us on Christmas day they took cheese and biscuits, a roast dinner, pudding and a cracker to pull, to one person who was spending the day alone.

Care files we checked contained records of people's preferred means of address, and how they wished to be supported. People supported by the service told us they had been involved in their care planning arrangements. One person told us, "I feel fully involved in my care and the carers are excellent". Information was available in the care plans to promote and foster positive relationships. For example, one person was

happy to have company but only for short periods. We were able to read about people's past employment. The names of peoples loved ones and what their pets were called. We saw what hobbies people had, their preferred routines and what they liked to watch on TV.

We asked how the registered provider protected people's confidentiality. Regarding sharing information, the registered manager told us, "Only people who need to know get to know information." We asked how they shared information with care staff. Care staff had a mobile phone provided by Carewatch (North). The phone was password protected and allowed care staff to access information only on people they were scheduled to visit. The information was stored on the phone for a limited period. This showed the registered provider had safeguards that respected people's right to privacy.

Carewatch (North) had a small end of life care team dedicated to delivering palliative care. Palliative care is for people living with a terminal illness where a cure is no longer possible. The co-ordinator in charge of arranging care told us, "We work with the person and their family, there are no set times for visits." They explained if they visit and it is not convenient, they leave and return later. This was confirmed when talking with staff. One carer told us, "I like palliative care. I like helping people. We ask them what times they would like us to visit." We noted feedback from families included, 'All the palliative care team treated [person] with such kindness and dignity whilst managing to make her laugh in the darkest times. They died at home in a peaceful and dignified manner.'

People who had a do not attempt cardiopulmonary resuscitation (DNACPR) forms were supported to keep this in a yellow folder. The community health teams were made aware there was a DNACPR in place. The purpose of a DNACPR decision is to provide immediate guidance to those present (mostly healthcare professionals) on the best action to take (or not take) should the person suffer cardiac arrest or die suddenly. This showed the registered provider had developed a flexible service to support people positively during their end of life care.

Requires Improvement

Is the service responsive?

Our findings

We looked at 17 care plans to see if the information held within them reflected people's individual care needs. We wanted to see evidence that the registered provider was responsive and documented people's preferences and wishes. We also spoke with people and their relatives to gain their feedback.

One person told us, "We have two carers as we use a standing hoist. They talk through everything and are very professional they keep me covered when I'm getting washed. I have various staff but mainly the same. They're always on time very rarely late." A second person told us, "Nurses [carers] couldn't be better. I had dizzy spells and they looked after me". A third person told us, "I was poorly and the carer didn't leave until I felt better. She was kindness itself."

About care plans, one person told us, "There's enough staff, I have a care plan and they do follow it." A second person said, "Yes I feel involved I have a paperwork care plan." A relative commented, "We are involved with everything, yes he has a care plan."

Care plans followed a structured format. They had life history, background, what a person likes and dislikes and what makes them who they are. We were told by the registered manager this information feeds into the needs assessment. The needs assessment looked at the whole person. They assessed consent, nutrition, continence and medication. They assessed cultural, religious and emotional needs. The form documented information related to the environment. For example, is the person able to open the door to let staff in? Do they require a hoist, use bed rails?

Not everyone had a care plan that directed care staff to deliver personalised responsive support. For example, one person had a very comprehensive guide on their moving and handling procedures. A second person had directions for staff to knock on the door, walk in and announce who they were. One person had requested male only carers. One person had requested specific staff to support them. We looked at rotas and noted these requests had been respected and honoured. One person did not want staff to wear a uniform. They did not want the public to see they were supported by carers. The registered provider had respected this and staff wore their own clothes.

However, we also noted, 'If the service user requires staff to follow particular guidelines to manage, or respond to, any aspect of their condition must be clearly documented as a protocol for staff to follow. e.g. recognising when a diabetic person may be having a hypoglycaemic episode.' We noted behaviours linked to hypoglycaemic episodes were not documented.

One care plan identified, 'I rely a lot on my carer.' It also stated '[person] uses hoist; ensure it is in the correct position before moving and handling'. The correct position was not identified. The documentation did not guide staff on how to minimise the risks involved in moving and handling the person.

We read in a second care plan, 'staff to support with any emotional needs when needed.' There were no guidelines on how to identify support would be required and how to deliver personalised care that would

meet the person's needs. A third care plan identified the person disliked showers and disliked using a hoist. There were no instructions to guide staff to deliver personalised care and acknowledge the person's preferences.

We visited four people in the Kendal area. One person did not have a care plan in their home. They said, "It was reviewed and taken away 5 weeks ago and never returned." We shared this information with the acting manager who arranged for a care plan to be delivered that day. A second person did not have an up to date care plan. A third person told us, "I hadn't had one for a few weeks but now I have got one."

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Person-centred care). The registered provider had failed to ensure records were accessible as necessary in order to deliver people's care and treatment in a way that meets their needs.

We asked about complaints received at Carewatch (North). We noted there was a formal complaints procedure. We were aware of one complaint prior to the inspection taking place. The registered provider had investigated in accordance with their policy and procedure. They had corresponded and met with the complainant and other relevant parties. The complainant was unhappy with the outcome. We discussed this with the acting manager who told us, "It could have been handled better from the start." They were honest in their consideration of their actions, stating, "On reflection and based on experience, the way I answer complaints has changed."

We spoke with a second person who had made a more recent complaint and met with the acting manager. They were happy with the outcome of the meeting. About the acting manager they commented, "I was reassured by him. He seems genuine."

We spoke with people about complaints, they told us they would complain if needed and felt staff were approachable. One relative confirmed this stating, "If I had any complaints I'd tell the carers".

Other comments we read included, 'To all who helped look after mum over the past year and during her final days, heartfelt thanks (we could not have done it without you)'. We also noted, 'I just wanted to send a note and thank carers who gave excellent care to my father.'.

Requires Improvement

Is the service well-led?

Our findings

We wanted to see if the service demonstrated good leadership and management and promoted a profession positive culture that was personalised and empowered people. We spoke with people who received a service, their relatives and staff. We received extremely positive and very negative feedback about members of the management team.

The Kendal branch of Carewatch had joined with Carewatch (North Lancashire) to become Carewatch (North). This merged service was managed from offices in Morecambe. One person who received a service in Kendal, told us, "It has deteriorated since joining with Morecambe." They explained office staff responsible for rotas were unaware of the area and this had a negative impact as staff had further to travel between visits.

We asked about the day-to-day culture of Carewatch (North). A member of the office staff told us they felt supported by the registered manager but stressed at the additional work due to understaffing. They further commented they felt a member of the management team was "arrogant". However, a second member of the office team told us the same person was helpful, stating, "I always call them in, they are very supportive." A third member of the office staff told us, "Communication is the key, and it has not been very good. It was fine up until recently, not very person centred anymore, more corporate."

One person who received a service from Carewatch commented, "[Member of the management team] is alright as a person but not management material, but I am only speaking from my experience." However, a second person told us about the same person, "They're right good, smashing. You can't beat them."

We shared these conflicting views with the management team and the area manager. The area manager told us they were aware of the concerns and had offered guidance to the management team on conflict resolution.

We recommend the service seek good practice guidance on leadership and communication.

Staff spoke positively about the quality officers. For example, one staff member told us, "[Person] is absolutely fantastic." A second staff member said, "I love it working here, [Quality Officer] is brilliant."

We looked at how the service monitored quality. Spot checks were undertaken whilst staff completed their visits. These were in place to confirm staff were punctual, stayed for the correct amount of time allocated and people supported were happy with the service. These included seeking the views of people they supported through satisfaction surveys and telephone monitoring. One person said, "We get reviews every six months. The office staff are approachable".

Whilst looking at the call monitoring system we noticed four incidents where staff had not logged in for a visit. Office staff were unaware of this until we brought it to their attention. This meant people who may be vulnerable could be at risk due to a lack of timely support to meet their identified care needs.

We asked about auditing the daily log sheets. These were the entries made by care staff after each support visit, on paperwork held at people's homes. 403 people received a service in the north Lancashire area. Their daily log sheets were to be audited each month. However, in February approximately 30 diary sheets were delivered to the office. In March, approximately 40 and April 30 diary sheets were delivered to the office for auditing. We were told by a staff member, it was difficult to get all the daily log sheets to the office. They commented, "One came in from August last year. Where that's been I don't know."

We asked who audited the daily log sheets in the Kendal area. We were told the quality officer completed this task. We clarified that the quality officer had input into the daily log sheets and was auditing their own work. We spoke with the area manager about this and asked if this was a safe and objective procedure. They told us they had recruited additional quality officers and no-one would be self-auditing in the future.

We asked if planned tasks were audited. For example, if person 'A' required a bath every morning or person 'B' required compression stocking on, did the auditor check daily logs to see if this had occurred. We were told this did not happen. We asked the person who audited the daily log sheets what training they had on the subject. They told us they did not have any formal training but had met with the Carewatch internal auditor when they had visited. We asked if they had the skills for the task and they stated they worried they may miss some information when analysing the data. We spoke with the registered manager who told us they recognised that auditing was a large task and needed additional time and scrutiny.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 (Governance). The registered provider did not have systems and processes in place for information to be reviewed and analysed by people with the appropriate skills and competence.

We spoke with the area manager after the inspection; they told us staff responsible for auditing had received training on the subject. They stated they had received formal training from the quality service improvement manager.

Additional audits were completed about the service annually by an internal auditor. These included safeguarding incidents, customer records, care records, staff records and staff training. Care reviews with people and their family members were undertaken to assess the service being delivered. One person told us, "We get a weekly rota and reviews every six months." A relative stated, "The care plans are reviewed every six months."

We spoke with a member of the management team responsible for ensuring care plans were accurate and current. They told us they were flexible to ensure the information was correct. For example, they rearranged appointments so family members who lived away could attend care meetings. They read the full care plan to one person with limited vision to ensure it was correct. This showed the registered provider had taken time to support people to express their views and had a structured system to review the care delivered.

The service had clear lines of responsibility and accountability with a structured management team in place. The registered manager had delegated responsibilities to members of the management team. For example, the service employed office co-ordinators who were responsible for an area each. This covered Kendal, Morecambe, Lancaster, Caton and Carnforth. They were responsible for allocating support in those areas. Quality Officers were employed to carry out initial visits, spot checks and observations, and monitored the paperwork in people's homes. Staff we spoke with knew who to approach regarding specific issues. This showed the registered provider had a framework to co-ordinate their resources effectively.

We saw staff had the opportunity to attend regular team meetings. We saw minutes that showed agenda

items reporting any concerns, professional boundaries when working in people's homes and training. One staff member said, "The staff meetings are good, I enjoy them." The quality officers had the opportunity to dial into weekly telephone meetings. One quality officer told us, "It's a different topic each week. It's a big help and you can send questions out to colleagues and gain more information." The registered manager and acting manager had regular meetings with the area manager. The registered manager commented, "There are guest speakers and information on any changes that may be happening in the future." Office staff told us they had a Monday meeting to discuss any issues that had occurred over the weekend and what support was required for the forthcoming week. One staff member told us they could request unscheduled meetings to discuss issues related to people being supported. This showed the registered provider had systems to share information, review, reflect and plan to maintain quality care.

The services' liability insurance was valid and in date. There was a business continuity plan in place. The registered manager's business continuity plan was a response planning document. It showed how the management team would return to 'business as normal' should an incident or accident take place.

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 The registered provider failed to follow processes that identified risk to the safety and welfare of people using the service and staff. The registered provider failed to adopt control measures that minimised the risk for people using the service and staff. The registered provider failed to ensure sufficient medicines were available. Documentation did not guide staff on the proper and safe management of medicines and creams. Regulation 12(1)(2)(b)(f)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Not all the systems and processes to manage quality and / or safety enabled the registered provider to respond appropriately and without delay. The registered provider had failed to ensure records were accessible as necessary in order to deliver people's care and treatment in a way that meets their needs Regulation 17 (1)(2)(b)(c)

Regulated activity	Regulation

Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The registered provider failed to follow effective recruitment and selection procedures that comply with the regulation and ensure that they make appropriate checks. Regulation 19(1)(2)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider failed to provide learning and development opportunities to maintain necessary skills to meet the needs of the people they care for and support. Regulation 18 (1)(2)(a)