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

Summary of findings

Overall summary

The inspection took place on 17 and 20 May 2016 and was announced.

At our last inspection, in April 2015, we found breaches of the regulations in relation to medicines, staffing levels, staff training and support. At this inspection we found that there had been improvement in how the service was managed and delivered. New staff had been recruited and the breach in relation to staffing numbers was met. We found, however, that further work was needed to make and sustain progress in the areas of medicines management and staff training and support.

Caremark Limited is a domiciliary care service that provides support to people in West Sussex, including in Pulborough, Henfield and Horsham. At the time of our visit the service was supporting 112 people, including six children, with personal care.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were at risk because guidance for staff on the support they required with their medicines was sometimes missing or inconsistent. Records of the medicines administered to people contained gaps where staff had not always signed to confirm that people had received their prescribed medicines.

Some people did not have a care plan in their home and other care plans did not reflect the person's current needs. This meant that staff would not have accurate information to refer to and put people at risk of receiving inappropriate or unsafe care. People and staff told us that there had been an improvement in recent months and that reviews had been taking place.

Risks to people's health and safety had been assessed and there was guidance for staff on how to minimise risk. We noted that there were no risk assessments in place for the use of bed rails and the registered manager took prompt action to address this.

Staff felt supported and said there had been improvement in the service. They spoke highly of the training they received. We found, however, that staff training had not always been updated and that supervisions and spot checks had not taken place at the frequency required by the provider. Further work was needed to ensure that staff understood individual needs and that people received effective care at all times.

Staff understood local safeguarding procedures and reported any concerns promptly. We found, however, that some staff who were supporting children had not completed child safeguarding training.

There were enough staff employed to meet people's needs. People told us that the timing of their visits and

the continuity of the staff who visited them had improved.

People spoke highly of the staff and told us that they treated them with dignity and respect. They told us that they had been involved in planning the care that they received. Staff understood how consent should be considered in line with the Mental Capacity Act 2005.

Staff supported people to prepare meals and to eat and drink if required. Where there were changes in people's health staff responded promptly and made referrals to other healthcare professionals when additional support was required.

People had been asked for their feedback on the service and the registered manager was responding to their concerns. The majority of concerns shared with us related to new staff not understanding people's needs and the fluency of English of some staff. The registered manager was monitoring the rotas to ensure that introductory visits were taking place so that staff were always introduced to a person and their needs before being required to provide support.

People felt able to contact the registered manager or staff if they had concerns and said that they received a good response. People told us that they understood how to complain.

The registered manager and provider had developed new systems to manage and monitor the service. These changes were delivering improvements. The registered manager had a clear action plan and was working to embed change and deliver continuity of service to people.

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

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

Some aspects of the service were not safe.

There were gaps in medication records and staff lacked guidance on how to support people with their medicines.

Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take, but staff working with children had not always received appropriate training.

Risk assessments were in place and reviewed to help protect people from harm but the use of bed rails had not been assessed.

Staffing levels had improved and there were enough staff to cover calls.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a marked improvement in staff training, supervision and appraisal but further work was needed to ensure that staff received consistent support to enable them to deliver effective care at all times.

Staff understood how consent should be considered and people were consulted on the care they received.

People were offered a choice of food and drink and given appropriate support if required.

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

Is the service caring?

Good

The service was caring.

People received care from staff who knew them well and cared

about them.

People felt involved in making decisions relating to their care and were encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Some people did not have a record of their care needs in their homes; other care records did not reflect people's current needs.

The registered manager and staff were working hard to address common concerns and to improve the service that people received.

People felt confident to raise any concerns and told us that they had noticed an improvement in the service.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and staff ideas were valued.

People and staff felt able to share ideas or concerns with the management.

Systems and processes were in place to monitor the quality of the service. The registered manager knew which areas of the service needed to be improved and had a plan in place to address these.

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Detailed findings

Background to this inspection

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

This inspection took place on 17 and 20 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

One inspector and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed three previous inspection reports and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We visited the office where we met with the registered manager, deputy manager, a care coordinator, a field care supervisor, the compliance officer, the training manager, the commercial manager, the provider and two representatives of the provider.

We looked at six care records, medication administration records (MAR) and visit records. We also reviewed six staff recruitment, training and supervision records, quality feedback surveys, minutes of meetings, staff rotas, quality monitoring reports and other records relating to the management of the service.

We visited three people who used the service in their homes and met with two relatives and five care workers. We telephoned 17 people, three relatives and a further three care workers to ask for their views and

experiences. We also received feedback on the service from a local GP practice which had involvement with some of the people the service supported.

Requires Improvement

Is the service safe?

Our findings

At our inspection in April 2015, we found that medicines were not managed properly or safely. This was because the records of medicines administered or prompted did not demonstrate that people had received their medicines in accordance with the instructions from their GP. We set a requirement and asked the provider to send us an action plan to show how they would make improvements. The action plan included an audit of all customer files, staff meetings and staff training and stated that the service would be meeting the regulations by 1 July 2015. At this inspection we found that improvements had been made but that concerns over how medicines were managed remained.

Since our last inspection the provider had introduced medicine books which contained the Medication Administration Record (MAR) for each person. These were issued monthly and returned to the office for auditing. We found that the frequency of gaps in recording had reduced but that MAR still contained gaps where staff had not signed to confirm that people had received their medicines. The system in place for auditing medicines had improved and the registered manager and provider had a clear picture of the issues that persisted. In the April 2016 audit 12 out of 15 medicine books checked contained gaps in the MAR. We read, 'Too many gaps' and, 'Two carers not filling out correctly'. Following the monthly audits, concerns had been addressed with individual care workers but there were still gaps in the records. As a result, the registered manager had arranged medication training for staff which was being delivered in the week of our inspection. A representative of the provider told us, "We've given them the tools and trained them but it isn't stopping the mistakes. It's a million times better than it was but there is still too much of it (gaps)".

We found that improvement was still required in the guidance about people's medicines to make clear to staff how each person should be supported. The training manager told us that staff were taught to refer to the medication assessment in people's care plans which detailed the level and type of support required. We found that this assessment, included in the medication policy used by the provider, had not been completed in the care plans that we reviewed. As a result, guidance for staff on the support each person required was inconsistent. In one case the person's care plan stated that staff assisted them with applying creams but there were no records in place for this. Another person's care plan stated that they did not require support with medication but there was a medication administration record (MAR) which had been signed by staff. Similarly we found that guidance on medicines prescribed on an 'as required' (PRN) basis, such as for pain relief, was not always available. The lack of information for staff could mean that people did not receive their medicines safely.

The provider did not have information on the medicines prescribed to each person and MAR charts had been handwritten. The registered manager told us that these were completed each month by care workers in the person's home. There was no system in place to check that all medicines had been entered or that the instructions were an accurate reflection of the pharmacist's script. We discussed this with the registered manager who told us that she intended to collate this information in the office and send out typed MAR charts each month. She said, "We're solely dependent on the carers filling it out right. It's a real worry".

We found that medicines were not always managed safely and that the requirement set at our last

inspection had not been fully met. The provider remained in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they felt safe, especially when they were supported by regular staff that they knew well. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. Where staff supported people by purchasing items for them, a clear record of transactions along with the receipts was maintained. Staff told us that they felt able to approach the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team.

The service supported six children whose ages ranged between three months and 16 years. We looked to see that the staff supporting children had been trained in child safeguarding. We found that these staff had not always completed this training. We discussed this with the registered manager who advised that due to staffing changes they did not currently have enough staff with in-date child safeguarding training to cover the calls. She advised that staff had been asked to complete the e-learning course, either for the first time or to refresh their knowledge. Following our inspection, the registered manager advised that five staff had completed the training, five had started and a further four were registered for it.

Risks to people's safety were assessed. People's care plans described each risk that had been identified and instructed staff on how support should be delivered to minimise the risk. For example in one person's risk assessment for personal care we read that they should be seated during their shower and to, 'Ensure any excess water is cleaned up to avoid unnecessary slipping hazards'. For another person who used a hoist to transfer, there was information on which sling loops to use for different types of transfer, such as from the bed to the commode or from the armchair to the commode. We observed staff supporting two people to transfer using a hoist. This was carried out safely and the person was involved at each stage. One person was given the control so that they could press the button to lower themselves into the chair when they felt ready. Where people were at risk of skin breakdown, staff were directed to be vigilant and to report any areas of redness. We observed that one person used heel protectors and that staff put a cushion between their feet which had been raised on a recliner chair. The person told us, "It's (pressure area) practically healed under their care".

Where people used bed rails to prevent them falling from bed, we found that this risk had not always been assessed. The provider's policy on the use of bedrails stated, 'The use of bed rails must always be risk assessed and a risk management form must be implemented as part of the client's care and support agreement'. By the second day of our inspection, the registered manager had highlighted the names of each person who used bed rails and asked the field care supervisor to complete the assessments by the middle of June 2016. It is important that the use of bed rails is assessed to ensure that the person is not placed at risk of entrapment in the rails or if they might try to climb over them.

The initial assessment included a review of the home environment with a view to promoting the safety of people and staff. We saw that lighting, access to electrical sockets, trip hazards such as loose carpets and waste disposal facilities had all been considered. In one care plan we read, 'Ensure the door is NOT on the latch as you leave and the key is returned to the key safe'. The provider had a business continuity plan in place which described the action staff should take in the event of traffic delays, severe weather or if the office should be inaccessible. We saw in the registered manager's report from January 2016 additional staff hours had been planned to help with 'winter resilience' and to ensure continuity of service.

At our last inspection, we found that there were insufficient staff which was impacting on the continuity of

care that people received and on the management of the service. At this inspection we found that staffing levels had improved and that the requirement concerning staffing numbers had been met.

Most people told us that the timing of their visits and the continuity in staff who visited them had improved. One person said, "I think they have been more consistent with carers recently, they used to not come sometimes but that doesn't seem to happen now". Another told us, "Things have settled down now and I usually get the same ones, it has improved in the last six months I would say". A third said, "I mostly see the same person. I am very happy with the care and I feel very safe with her". Staff also spoke of an improvement. One said, "I have permanently allocated calls and I know my rota". Another told us, "There is a good staffing level at the moment". The registered manager monitored the continuity of staffing weekly. In the week of our visit, 96% of calls were permanently allocated to specific staff members. The care coordinator explained how they had some staff leave and also some people who were receiving additional calls. She told us, "We're asking people who (which staff) they would like trying to work out a new fit".

At the time of our inspection, new staff had been recruited to the field care supervisor and care coordinator roles. The provider had also increased the number of field care supervisors from three to four with the aim of reducing the pressure on the staff in this role and improving the service that people received. Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

Requires Improvement

Is the service effective?

Our findings

At our inspection in April 2015, we found that staff had not received appropriate support, training, professional development, supervision and appraisal. We set a requirement and asked the provider to send us an action plan to show how they would make improvements. At this inspection we found that the provider had made progress towards meeting the regulations but that further work was required to ensure that people received effective care at all times and that staff attended regular training, supervision and appraisal.

People had mixed views on the skills and competency of staff. The majority were satisfied and told us that staff were very good but some raised concerns over new staff who they felt lacked experience. One person said, "The trained ones are fine but they sometimes send new ones who are not so good". A relative said, "My husband has a stand aid and some are not trained to use it, it depends who comes". The registered manager explained the system to ensure that introductory visits took place when staff visited a person for the first time. This system was designed to help ensure that people were introduced to new staff and that staff understood people's needs and wishes. We saw that there had been several incidences of introductory visits not taking place. In the March meeting with the provider we read, 'It is very disappointing to find that yet again intro visits/shadowing are not always being carried out'. We saw that details of any introductory visits required were now included on the weekly handover and that, as backup, staff had been encouraged to let the office know if they were scheduled to visit someone for the first time. One staff member told us, "If I have a new client added I will get a message to meet with my supervisor for her to introduce me". The registered manager said that introduction visits were, "Definitely happening".

New staff attended a week long induction which consisted of practical and e-learning courses. The provider had an in-house training manager who was based at the office. This meant that if staff were unsure of any aspects of their training they were able to quickly access additional support. The training manager told us, "I listen to what they say. I give them as much time as they need. People [referring to staff] are at different levels". Once their training was completed, new staff shadowed an experienced member of the team. The field care supervisor told us, "After training they'll go out with an experienced carer for three days at least. If that carer has concerns they will ring and I'll go and check or refer back for more training/shadowing". The competency of new staff was assessed by the field care supervisor before they started to work independently. It was also reviewed as part of the Care Certificate which new staff were required to complete. This is a nationally recognised qualification covering 15 standards of health and social care. One new staff member told us, "I had a week of shadowing for eight to twelve hours a day. I met everyone and I felt ready".

Some people shared concerns that some new staff struggled to communicate in English. One person told us, "One carer could not speak much English she didn't know what to do. I tried to explain but she didn't understand me". Another said, "Some do not have good English but if two come and one speaks good English we can work it out between us". The registered manager and training manager were aware that some overseas staff, due to working in a second language, required additional time to absorb the training, as well as help to navigate around the local area. The training manager told us that following feedback,

additional training was being provided, either one to one or in small groups.

Staff told us that the training had equipped them with the skills and confidence to support people effectively. The provider's mandatory training included moving and handling, medication, safeguarding, infection control, food hygiene, fire safety and first aid. At the time of our visit training in the Mental Capacity Act 2005 and dementia awareness had just been added to the mandatory list of training. There was a training room at the office, equipped with a bed, hoist and slings. The training manager explained that the practical training included washing and dressing, skin integrity, shaving, oral care, slide sheets and catheter care. We saw that staff had been asked to evaluate the training they attended. Comments included, 'I felt thoroughly supported and able to ask any questions I had' and, 'Everything worked well for me, (training manager) made everything easy to understand'. In response to a survey by the provider, ten of the 11 respondents felt the initial training and practical induction were useful. Staff were able to pursue further training, including diplomas in health and social care. Additional courses that had been completed included Percutaneous Endoscopic Gastrostomy (PEG) feeding (a tube placed directly into the stomach through which fluid and nutritional fluid can be delivered), nutrition and hydration and supporting children.

We looked at the training matrix and saw that practical refresher training was overdue for 18% of staff and 13% of staff were overdue a theory update. The training manager told us, "Getting them (staff) to physically come in is a battle". The registered manager was aware that training was overdue. The compliance officer position had been newly created and this staff member had put together an updated matrix to show the status of staff training. The compliance officer told us that they were adding refresher training on the rotas of individual staff members and scheduling observations for new staff to complete the Care Certificate.

Staff told us that there had been an improvement in their terms of employment and that they felt supported in their roles. All staff had attended a supervision meeting in the second half of 2015. The feedback from staff had been reviewed and the provider had taken action to make improvements. One staff member told us, "I have total support from my supervisor; I can call any time, any hour". Another said, "They are very good. I can't fault the support. They're there if I need them". Supervision included one to one meetings, spot checks and an annual observation of moving and handling and medication administration. In addition, staff were scheduled to attend one appraisal meeting each year where their performance and professional development goals were discussed. A list of supervision and appraisal meetings due could be generated from the computer system. We saw that, although all staff had received supervision in 2015, this was not always at the frequency required by the provider. Some new staff who started in 2016 had not yet been supervised or had their practice observed. The registered manager told us that they would be in a position to catch up once the new field care supervisors were in post.

We found that further work was required to embed the improvements in staff training, supervision appraisal to enable staff to deliver consistently effective care. The requirement set at our last inspection had not been fully met and the provider remained in breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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 so that they can 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. People told us that staff

respected their preferences and decisions. We saw in the daily notes that people had occasionally refused aspects of their planned support and that this had been respected. Most people had signed their care plans to demonstrate their agreement. Staff were able to describe how they considered people's capacity and consent in their daily work. We saw that all staff had been given a laminated card setting out the five principles which underpin the MCA. The training manager told us that MCA was discussed on induction and that further training was available. At the time of our visit, half of the staff team had completed this further training, which was to be rolled out as mandatory training for all staff. Where people had appointed a representative to act on their behalf, the registered manager had a clear record of this.

Some people were supported to prepare meals and drinks and to ensure that they ate and drank enough. People's care plans included details on their dietary preferences. For example, 'I usually like porridge with a spoonful of honey on top and a cup of tea in the morning. Please ensure my tea is in the flask mug, I use soya milk only'. We accompanied staff on a lunchtime visit to one person. We observed that they offered them a choice of meal. The person chose an omelette. They told us, "It was lovely but very filling". Another person said, "We go through my larder together; we discuss my food for the week and she (care worker) does my shopping". Staff provided drinks to people and encouraged them to drink. We saw one staff member kneel beside one person to hold the cup and help them to drink through a straw.

Where there was a concern that people may not be eating sufficient amounts, staff maintained a record of the food served and detailed when it had not been eaten. One staff member said, "If I am concerned about my client not eating I will advise the office and they will inform the family; we have fluid charts and nutrition charts to fill in". We saw that records of food and fluid intake had been maintained and were completed daily. Since our last inspection, the recording of the amount or volume consumed had improved. This helped to provide an accurate picture of the person's intake. Staff told us that they reviewed the record form the previous day to ensure that the person was receiving appropriate support. We noted, however, that the fluid charts did not include a target daily intake and that they had not been totalled. This practice would help to demonstrate that people were receiving effective support. We shared this feedback with the registered manager during our visit.

People were supported to maintain good health. People had been referred to the GP and district nurses when required. Staff had also been involved in helping people to access services, such as for the installation of grab rails, ramps and wet rooms. The registered manager of a local GP practice told us, 'We have no issues with Caremark. They seem well organised, deliver what they have been asked to, are timely with their responses and have good communication with all agencies'.

Good

Is the service caring?

Our findings

People spoke highly of the staff who supported them and told us that they were kind and caring. During our visit to one person's home we heard laughter coming from the bathroom as staff were assisting the person to get ready for bed. One person told us, "They're very good to me. I pull her leg, we get on very well". In the provider's survey from March 2016, one person had written, 'I am well satisfied with the care I am given. Your staff are always cheerful and we often have a laugh'. People told us that staff knew them well and that they valued their support. In response to the provider's survey we read, 'Very pleased with the carers. They are willing and exceptionally dedicated to doing their work to the best of their ability and training' and, 'I do think all your staff are wonderful'. A relative had written, 'I have been very happy with the care (name of person) has received. Carers have all been wonderful and made my life easier'.

During our visits to people's homes we observed that there was a good rapport between people and staff. People appeared relaxed and engaged in conversation with staff about topics of mutual interest, such as what had been happening in a recent soap storyline on television. One person told us that some staff would stay on after the call just to chat if they had a gap before their next visit. One community professional had written to the provider to say how impressed they had been by one staff member. They wrote, 'I would like to say what a fantastic carer (name of staff member) is. I had stressed (name of person) out and she calmed him down and was very good with him'. The provider had received multiple compliments from people and their relatives through reviews and in cards that had been sent. In one review we read, 'Carers are excellent, helpful in every way'. In a card of thanks, 'Nothing is too much trouble for (name of staff member); she is kind, thorough and friendly at all times'.

People were involved in planning their care and several people spoke about recent reviews that had taken place. People felt that staff knew what was important to them. One person told us, "They understand me". Another said, "I know them and they know me well". Where staff had left the service, people were consulted on which staff members they would like to cover those calls. The care coordinators were able record preferences for particular care staff on the system. They were equally able to 'prevent' a particular staff member from being allocated to support a person if this was the person's wish.

Staff encouraged people to be as independent as they were able. People's care plans included information for staff on what they were generally able to do for themselves. In one we read, 'I will wash my face and some of my body that I can reach. CSW (Care and support worker) to help in other areas'. One person was receiving physiotherapy and staff assisted them with daily exercises to help maintain and improve mobility. This support was recorded in the daily notes for the person and they confirmed to us that staff assisted them as part of their regular visits.

People told us that staff respected their privacy and treated them with respect. We saw that care plans included individual details about how people wished to dress. In one we read, 'Please ensure my hair is brushed, dried and put up in a pleat using clips and pins'. One person told us,
"They dress me to whatever I want". Staff described how they would allow people privacy in the bathroom, assist them to keep their clothes clean when eating and not answer the telephone whilst on a visit. One said,

"The client comes first when it comes to receiving care. If I am showering them and the door goes then they just have to wait". Staff were observed by their seniors to ensure that they were treating people with respect. The field care supervisor told us, "When I'm watching what they're doing, I look at it as if that were my Mum there; are the speaking to her properly and communicating all the way". One relative had written a card of thanks which read, 'They all showed both (name of person) and the family great respect and kindness'.

Requires Improvement

Is the service responsive?

Our findings

People were at risk when visited by staff unfamiliar with their needs because information on their care and support was not always available in their homes. Two people we visited did not have a care plan in their home files. Another person we spoke with on the telephone said, "I don't have a care plan, my carer has asked for it". In a response to the provider's survey one person had written, 'My care plan is still not in my file'. The absence of a care plan in people's homes meant that there was no information for staff on how to support the person or on what was required of them during the visit. One person told us, "The new ones do not know my needs I have to explain". Another said, "Some carers who arrive do not know how to cream my legs. Sometimes it hurts". A relative said, "In the past I've had to step in as someone has been sent who does not know my son's complex needs".

Some people's care plans did not reflect their current needs. In one we read that the person spent the afternoon in bed. After the lunchtime visit we noted that they were in their chair. Staff informed us that now the person's pressure area had healed, they no longer needed to spend the afternoon lying down. Another person's care plan said that they used a walking frame. We observed staff hoisting them to a wheelchair and questioned this. The staff member told us, "(Name of person) can't walk". The records of the support required had not been updated to reflect changes in the person's health and care needs.

Our conversations with people indicated that there had been an improvement in recent months and that reviews of their care had been taking place. Some care plans had been updated in the office but had yet to be returned to people's home files. Of the 17 people we spoke with by phone, ten told us that their care plans had been recently updated. We saw that care reviews featured on the registered manager's action plan. In the review of actions with a representative of the provider in May 2016 we read, '(Reviews outstanding) massively reduced, working in priority order, understaffed on field care supervisors, however team are working together'. On the list of care reviews due we saw that reviews for eight people were overdue by more than a year. The compliance officer told us, "That list was literally pages and pages". The registered manager explained that they had prioritised reviews, starting with those people who had the highest needs or whose support needs had changed dramatically. The registered manager anticipated further improvements once the team of field care supervisors was fully staffed and due to the fact that the provider was introducing an electronic system to manage care records. This would mean that assessments and reviews would be carried out using portable computers and information would be uploaded directly to the system. Although this was an area that was improving, further time and work was required to ensure care records were consistently updated and readily available.

The updated care plans provided a clear picture of each person's needs and preferences. In one we read, 'Please place the small table next to my bed with my lifeline (a personal emergency alarm), tissues and clock on it' and 'In winter months please put my vest on the radiator'. In another, 'I like to wear a nightie in bed and usually my night cardigan' and, 'I like to dress in the bedroom, so please ensure I am supported using my walking stick to the bedroom'. There was detail on how people liked to be addressed, their interests, family and professional life. In the registered manager's meeting with the provider from March 2016 we read, 'A care plan should be detailed enough so that a complete stranger can go into the home and deliver the

care and support exactly how the client wishes in a respectful, dignified and caring way. The client should not have to continually repeat themselves and teach new staff how to support them correctly every time there is a change in carer'. Through the updates to care plans and by insisting on introductory visits when staff visited a person for the first time, the registered manager was working towards this goal.

People expressed concerns over the number of different care workers who visited them, new care workers who did not know what to do and the level of English of some staff. These concerns were also reflected in client reviews and in some responses to the provider's survey. One person told us, "Just recently they sent two new carers. It was ridiculous, chaos. I rang up and complained and they sent someone to see me and she agreed that is not acceptable and she would sort it out". Another had said, 'When mobilising I lack confidence in certain carers'. Others expressed frustration when they were not advised that a care worker was running late or if there was to be a different staff member to the one listed on their rota.

Most people told us that things had improved and that they generally had visits from a regular group of staff. One person told us, "The ones I have now are always on time or they let me know if they will be late". A relative told us, "The field care supervisor came out a couple of months ago. We discussed timing and continuity. It has improved since the meeting. There is a big difference". Another relative who had raised concerns told us, "They do listen. I sent a letter to (registered manager). She did phone me". The registered manager told us that they had worked hard to improve the continuity of care and that she was closely monitoring the rotas to ensure that introductory visits were scheduled. Coordinators told us that they tried to pair new staff with an experienced member of the team, especially where the person required support with moving and handling. The field care supervisor explained that they had changed the mobile network to give better coverage for the on-call phone, as they had instances of it going directly to voicemail when in an area of poor reception.

We noted that people had made suggestions or requests for changes through a variety of means, including reviews, the provider's survey, in response to telephone monitoring by the service or directly to their care workers. We asked the registered manager how they captured all this information to ensure that nothing was missed. At the time of our visit there was no system in place to gather this information together and ensure that the service responded accordingly. The registered manager told us that they intended to add it to their existing action log.

People understood how to make a complaint about the service and information on the procedure was included in the folders kept at their homes. One person told us, "I would feel confident at raising a complaint". We saw that action had been taken in response to complaints, such as by reviewing travel time for some calls requiring two staff to deliver care, where staff had regularly been arriving at different times. The registered manager told us that there had been a marked reduction in the number of complaints they were receiving. She told us, "There is a process and a structure for responding. It's a slicker organisation".

Good

Is the service well-led?

Our findings

Since our last inspection, there had been changes and the service had improved. A new registered manager started in post in November 2015 and was registered with the Commission in January 2016. The registered manager was well aware of the areas of concern that we identified during this inspection and she had plans in place to make improvements. There was a positive and open atmosphere at the office. The provider and registered manager openly acknowledged what had gone wrong and where further work was needed. The rating received following our last inspection was displayed on the provider's website. A care coordinator told us, "The office is running a lot better, everyone is happier". The registered manager said, "We've got a team again. We've built it gradually. It's a happier place to be".

The roles and responsibilities of staff had been clarified and staff understood what was expected of them. Office staff were no longer required to cover care calls which enabled them to focus on their core tasks. A new role had been created for a compliance officer. This person had recently started in post and had responsibility for monitoring the status of care reviews, staff supervision, training and spot checks. The provider had also increased the number of field care supervisors and new staff had been recruited to these posts. He told us, "We've had an issue with field care supervisors. Two have gone in the last two months but by the start of next week we should have four".

The registered manager was well-regarded and staff told us that she was approachable. One said, "The new manager is lovely we are always made to feel welcome in the office". The registered manager told us, "Once the foundations are in place I intend to spend more time in the field". She told us that this would include meeting with people who used the service and monitoring the work of the field care supervisors. She told us, "We've really had to take it back to basics".

People's had been asked for their views on the service in a survey sent by the provider in March 2016. At the time of our inspection, 28 responses had been received but the responses had not yet been analysed. Nevertheless, people spoke to us of progress. One said, "The consistency of carers has got better in the last couple of months". Staff views were sought via supervision, meetings and surveys. This feedback was used to make improvements to the service. One staff member commented in their supervision, 'Very impressed by the changes, much more professional'. Another said, 'Very happy with work, things have improved a lot. Travel time much better'.

Communication with staff had improved and staff were encouraged to share their views. Staff meetings which the registered manager had described as, "Sporadic" were now held quarterly. The minutes of the meetings included an update on how points raised at the last meeting had been addressed. This was in the format of, 'You said/We will' and included who was responsible for the action and the timescale for completion. In the invitation to the most recent staff meetings we read,
'Thank you for taking the time to come in today and please use this time to let us know if you have any issues or if there is anything you feel we can be doing better'. Whereas staff had at one point received their rota for the coming week on a Friday this was now sent out on a Tuesday or Wednesday and staff were required to text the office to confirm receipt. On a Friday, the registered manager, care coordinators and

field care supervisors met to ensure that everything was in place for the week ahead. These meetings were documented on a handover form which included a list of introductory visits and any people whose care was to restart, for example after discharge from hospital. There was a system of text messaging to share important information or changes with care workers.

There were systems in place to monitor the quality of the service and to make improvements. The registered manager maintained a log of incidents, missed calls, complaints and compliments. Each item was addressed and closed once resolved. The registered manager told us, "I am logging everything just to get my head around what is going on". Incidents were reviewed to see if there were any trends. We saw that action had been taken by the service, for example by making a referral for one person who had suffered a number of falls. On a weekly basis, the registered manager provided a report to the provider which included key information about the service, such as the figure for permanently allocated visits, new customers and any safeguarding or complaints raised. Monthly audits of the MAR and daily records were completed and the results collated. This helped to identify any patterns. As a result of these audits, the registered manager had addressed isolated concerns with individual staff members and had arranged additional training for all staff in managing medicines.

The registered manager received monthly visits from a representative of the provider and was working to an agreed action plan. This action plan started in December 2015 and was added to and reviewed at each visit. The representative of the provider told us, "She's (the registered manager) reduced it quite significantly. I'm crossing things off which is such a nice feeling". The registered manager said, "It was horrendous to start with but now we're down to a sensible action plan. It's like a mini audit every month". The registered manager said, "We have achieved a lot. The place feels more professional and we are providing a better service".

This section is primarily information for the provider

Action we have told the provider to take

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

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff had not always received appropriate training, supervision and appraisal. Regulation 18 (2)(a)