AS Chiltern Homecare Ltd

Caremark (Chiltern & Three Rivers)

Inspection report

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Date of inspection visit:
28 December 2018

Date of publication:
17 January 2019

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
• The service's office is based in Chesham. Care is provided in the surrounding areas including Amersham, Rickmansworth, Chorleywood and Croxley Green.
• The service is part of the Caremark brand; a large group of domiciliary care providers.
• The service provided personal care. People received care as part of a package where care workers visited a set number of times each day. A small number of people had full time 'live-in' carers who provided 24-hour care in their house.
• At the time of our inspection, 55 people used the service and there were 30 staff.

People's experience of using this service:
• People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was very safe.
• People's risks were assessed and strategies put in place to mitigate the risks.
• People's likes, preferences and dislikes were assessed and care packages met people's desired expectations.
• People and relatives provided consistently positive feedback about the care, staff and management. They said the service was caring, timely, effective and well-led.
• People's care was person-centred. The care was designed to ensure people's independence was encouraged and maintained.
• People were equal contributors to their care plans and reviews. People, and where needed families, were actively engaged in formulation and changes to care packages.
• The service had a strong and robust management structure. The provider had implemented good systems to ensure they continuously measured the safety of people's care and quality of the service.
• The service met the characteristics for a rating of "good" in all the key questions we inspected. Therefore, our overall rating for the service after this inspection was "good".
• More information is in our full report.

Rating at last inspection:
• This is the first inspection of this service.

Why we inspected:
• This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our findings below.

Is the service effective?

Good

The service was effective.

Details are in our findings below.

Is the service caring?

Good

The service was caring.

Details are in our findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our findings below.

Caremark (Chiltern & Three Rivers)

Detailed findings

Background to this inspection

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

Inspection team:
• Our inspection was completed by three inspectors and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our expert by experience had knowledge about personal care of adults within the community.

Service and service type:
• This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to children, adults and people with dementia.
• The service is required to have 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. At the time of our inspection, a manager was registered with us.

Notice of inspection:
• Our inspection was announced.
• We gave the service 72 hours' notice of the inspection visit because staff were often out of the office supporting staff or providing care. We needed to be sure that they would be available for the site visit.

What we did:

• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).
• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We telephoned and spoke with nine people who used the service and their relatives or family member.
• We spoke with the provider's nominated individual, two care coordinators, the field care supervisor and two care workers.
• We reviewed six people's care records, three staff personnel files, audits and other records about the management of the service.
• We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes:
• New staff were provided with safeguarding training during their induction, which was organised by the training manager.
• The training included face-to-face training, practical training and online mandatory training about safeguarding people from abuse and neglect.
• Staff were required to repeat the safeguarding refresher training every year.
• Whistleblowing was covered within the mandatory staff training and information was also available in the employee handbook.
• There was an instance in August 2018 when there was a whistleblower, where a care worker had acted inappropriately. An investigation took place and appropriate action was taken by the management. This meant the service cared for people's welfare.
• Staff said they would approach their line manager, the registered manager or the nominated individual if they needed to whistleblow about another staff member or care practices.
• During team meetings, there was a 'hot topic' discussion. This would be a subject of recent interest or where updates for staff were needed and safeguarding was included as one of the subjects.
• Staff were also reminded about professional boundaries and the use of social media.
• The service catered to a very culturally and linguistically diverse group. Staff were trained in equality and diversity, and senior staff introduced care workers to people commencing new care packages. For example, one person who did not speak English had translated words in their house for care workers to use when providing care.

Assessing risk, safety monitoring and management:
• When the service received an enquiry about a care package, they filled out a "client enquiry form" which asked a series of set questions. These included care needs and health conditions. This also documented the requested call lengths and call times.
• The care supervisor completed the initial assessment so that the information collected was scrutinised for all potential and actual risks.
• Notes from social workers were also used, when the referral was made by the local authority or other healthcare facility.
• The service could assess and start care for a person within 48 hours of a hospital discharge. There was a "rapid response" document that could be used to record a person's risks in a shortened format.
• An assessment was completed with people and their relatives. This included the person's house and environment, personal care, medicines, nutrition and hydration, mobility and methods for falls prevention.
• People's risk assessments were updated at least annually, and then based on risk of particular care, they were reviewed more regularly.
• Comprehensive reviews were conducted when there was a change in the person's requirements, for

example a person discharged from respite whose mobility had deteriorated.

Staffing and recruitment:
• Staff were deployed based on staff members' availability and the days and times they were available to work.
• Staff were allocated to calls geographically so that it reduced travel times and was based on where people lived.
• Reducing the travel time between calls helped to ensure the care workers were punctual to their calls.
• Late calls were classed as anything where the care workers arrive more than 20 minutes beyond the allocated start time of the call. Late calls were actively monitored and investigated by the office staff and management team.
• An electronic system was used for log in and out of calls to people's house. This recorded the length of time staff spent with the person.
• Monthly checks of late calls were analysed and information was sent to stakeholders, such as commissioners. Themes and trends were checked to identify the root cause of a common late call, for example, specific care workers or roadworks. There was a theme identified, which was road works and action was taken by spreading out the call times by staff and explaining this to people who used the service.
• Missed calls were monitored using the electronic care scheduling systems. There was 'live tracking' completed by the care coordinators to look for alerts and contact care workers to assess any situation. A remedy would be put in pace to deal with any potential missed calls.
• People and relatives could telephone to cancel their care calls if needed.
• The service ensured that they were not overloaded with too many care calls and would refuse new care packages if there was no capacity to meet a person's expectations.
• Care workers were matched to people's needs, such as their gender and cultural or linguistic preferences.
• During employment procedures, the service completed a telephone interview and a face-to-face interview. The prospective employee was required to complete an application where the service checked written and spoken language skills. The staff members were required to complete functional tests before they were employed.
• There are cooking lessons with the trainer, to understand traditional phrases such as "bubble and squeak".
• Recruitment practices were robust. This included checking information in the staff personnel files was complete, and setting out the files to enable finding documents quicker.
• Checks included asking applicants for a full employment history, checking the reasons why staff had left their previous roles, obtaining a criminal history check from the Disclosure and Barring Service and obtaining references from prior employers.

Using medicines safely:
• Care workers receive a combination of theoretical, face-to-face and practical training in medicines safety.
• Care workers shadowed an experienced care worker in the field and then were supervised with giving medicines.
• Not all people who used the service received medicines. Some people required prompting by staff and others required full administration.
• Annual competency checks of care workers were required. This ensured they remained safe to continue to administer medicines.
• Medicines administration records (MAR) were recorded in an electronic care system. The system helped detect whether people received their medicines in a timely way, and that staff had signed for the administration of the medicines.
• We found one person's medicine was not being administered at the correct time according to the manufacturer's instructions. We encouraged the service to contact the GP and community pharmacist to clarify.

• The service did not have access to the British National Formulary (BNF) at the time of our inspection. The BNF lists all important information for anyone who administers medicines. The nominated individual advised access to the BNF would be obtained following our site visit.

Preventing and controlling infection:
• Staff had access to personal protective equipment, such as disposable gloves, aprons, shoe covers and alcohol-based hand gel.
• Staff completed training in infection control and were required to complete the training at regular intervals.

• The training manager was responsible for infection control management. It was their role to oversee effective infection control across the service.

Learning lessons when things go wrong:
• When care workers become aware of any accidents and incidents, the called the office and details were recorded on an incident form.
• The forms were passed onto managers for review and, where necessary, investigation.
• A log of incidents per month was kept, to tally up the number and analyse any trends or themes.
• Where necessary, incidents and accidents were reported to third parties.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

People's outcomes were consistently good, and their feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• The care plans showed evidence of the field coordinator's assessment of people's needs in addition to the assessment by the local authority or clinical commissioning group before care provision started. This involved collecting information about the person's social history, their previous occupation and preferred activities, communication needs (if relevant) and tasks they needed help with. The assessment also took account of information provided by other family members. It was recorded in a standard format so was easy for care workers to find information.
• Care workers' tasks were listed for person, at each visit. There was information about people's behaviour, for example a person who felt frustrated by their health situation and dependence on others; or another person who was alcohol dependent.
• The assessment also ensured that the physical environment of people's homes was safe for care workers. For example, one plan noted that the floor between two rooms was on a slope, but that the patterned carpet meant the slope was hard to see.
• The assessment assessed the risks to each person, such as risk of falls, of dehydration, of weight loss, of dressing in appropriate clothing or non-compliance with medicines.
• The service had recently implemented an electronic care management system which enabled office staff to monitor and audit care provided including medicines given.
• Records showed care workers recorded whether the person had eaten all their meal and whether they had any drinks. Care workers were aware of the importance of older adults having a good fluid intake to help avoid infections. This was specifically mentioned in at least two care plans where people were particularly at risk of infections.
• The minimum length of each visit was 30 minutes. Commissioners defined the length of visits, although we saw examples on file of agreement to longer visits as people's needs changed. Some people had visits of 30 minutes, 45 minutes or an hour, depending on the support needed. A few people had live-in care workers, for example a person having palliative care who needed support with all tasks of daily living.
• All people needing to be moved with hoists were attended by two care workers in line with good practice.
• The service aimed to introduce care workers to people before a package of care started, although there had been a period when that had not been possible because of staffing shortage.
• The care plan of a person cared for in bed mentioned fire safety and that in the event of fire the person should be covered in wet towels and a damp towel should be put at the base of the door to prevent smoke entering the room.
• Caremark's head office had staff members responsible to ensure that standard processes were in line with national standards and any updates required were passed on to local offices.

Staff skills, knowledge and experience:

• Staff told us new care workers had an induction and undertook mandatory training (including fire safety, environmental safety, infection control, manual handling, nutrition and hydration and first aid). Some training was online and some face to face, for example moving and handling. Medicine administration was observed.
• The service had a training area on the premises with a bed, chair and hoist. Care workers shadowed an experienced staff member as part of their induction before working alone, and did not work alone until confident to do so.
• Staff completed the Care Certificate, an agreed set of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. We saw examples of completed Care Certificates. Staff said they were encouraged to develop their skills. One staff member was undertaking a diploma in social care and was being encouraged to learn about palliative care through volunteering in a hospice. Staff said they had recently been asked about their interest in developmental courses, such as on dementia and autism.
• Staff said training updates were annual, for example, manual handling and safeguarding. The provider's training matrix demonstrated staff were up-to-date with their training.
• Staff had an opportunity to comment on training and training needs in the annual staff survey. Care workers said they were also able to talk about training in supervisions and annual reviews.
• One member of staff was not confident about medicines administration. They raised this with a supervisor and received one-to-one support to reinforce completion of MAR charts and how to encourage people to take their medicines.
• Two care workers said office staff were always there to give help and support if needed, including out of hours. We observed calls from care workers to ask advice, for example, about calling 111 or refused medicines.
• Care workers confirmed that food hygiene was part of mandatory training. They were aware that older adults were potentially more susceptible for food poisoning than younger people.

Supporting people to eat and drink enough with choice in a balanced diet:
• Where meals were provided as part of the care plans, the plan indicated that care workers should offer the person a choice of meal. These were microwaveable meals, as care visits were not long enough to cook and serve a meal.
• Care plans recorded food preferences, where relevant. Relatives bought most of the food so staff were not involved in ordering meals. For example, one plan showed what a person liked for breakfast, either toast or cereal. Another person liked to have cereal or porridge.
• For one person who had been refusing an evening meal and tended to have alcohol instead, the service had changed the time of the call so the person could eat earlier in the evening and as a result the person ate their meal and reduced their alcohol consumption.
• We saw explicit documentation in one plan about preparation of hot and cold drinks, and food and drinks that should be left within reach of a person whose mobility was impaired so they could have snacks between care visits.
• In another plan there was information about the person's soft moist diet, specifying what they could and could not eat. No one was on a strict food or fluid monitoring regime, but a care worker told us they would record whether a person had eaten the whole meal or only part of it. They told us they would record the meal a person had eaten, so that the next care worker would offer different choice of meal and therefore encourage a balanced diet.
• Both care workers we spoke with were aware of culture and diet. One cared for a person who did not eat beef, and was mainly vegetarian. They were also aware of allergies such as to gluten or dairy products.
• Staff said that if a person was eating noticeably less than normal they would mention it to the office.

Staff working to provide consistent, effective, timely care:

• A few people's responses to the client survey stated that calls were not always on time and two people said their visits were at the timing that suited the agency, not them. For example, one person's morning and lunchtime visits were only 2 hours apart.
• The rota coordinator said that they tried to avoid such situations.
• They explained that not everyone could have the visits exactly when they would like, but tried to accommodate preferences, where possible. There was a balancing function between continuity of care, travel distance, care worker availability and preferred shifts. However, one family recognised and accepted there were some constraints and said they had asked for a later evening slot for the last call, "…when one became available".
• One person said they would prefer more consistent care workers at the weekend.

Supporting people to live healthier lives, access healthcare services and support:
• Care workers did not engage directly with professionals, unless a doctor or district nurse happened to visit the person during a person's visit. However, we saw a good example of where a care worker had encouraged a person to do their physiotherapy exercises to improve their mobility. The person had managed to go in their garden for the first time in a year.
• Two care workers gave examples of when they had made 111 calls, for example about whether it mattered if a person had refused their medicines or if someone was feverish.
• Where a person confined to bed had pressure sores, we saw that the district nurse was involved with care
• We saw that one person had been referred for an occupational therapy assessment as they had increasing difficulty with acts of daily living and their care plan was then changed.
• One person received palliative care. The care workers were aware of this and provided care jointly with the family.

Ensuring consent to care and treatment in line with law and guidance:
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 with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

• Care workers said they always asked consent and explained what they were doing when they gave personal care. We saw records for a person who had refused a meal or refused medication. This was noted by the care worker during the visit.
• Mental capacity assessments were not the responsibility of the service, but had sometimes been done when the person was in hospital. However, information about people's capacity was available to care workers.
• The supervisor gave us an example of a person where there was a question about capacity as they were prone to infections and therefore to episodes of confusion. The GP was waiting for a time when the person was clear of infection to assess their capacity.
• For one person who had been assessed as not having capacity, there was evidence on the person's file of best interest decisions involving the CCG and family. For another person, the social worker was involved in agreeing the plan. Staff understood the concept of mental capacity.
• People's files recorded where there was enduring or lasting power of attorney, but the service did not keep records of the actual documentation.
• One person was subject to deprivation of liberty order. This person was given medicine covertly if they refused to take it. Staff understood what deprivation of liberty meant.
• One care worker gave an example of a person who had gone missing from their home repeatedly and got

lost, and was now restricted from going out for their own safety.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported:
• People and families provided consistently positive feedback about staff and the service.
• They also confirmed how care worker would work to people's personal instructions and cared for them in the way they chose.
• Comments from people demonstrated a very caring approach by the service. Feedback included, "My carer is an absolute joy", "Carers have the right attitude, positive uplifting, cheer us all up", "All staff are very good, all friendly and caring" and "Competent staff and well trained."
• Feedback from relatives was also complimentary. They stated, "Good natured staff, excellent rapport, great with dad", "I am reassured and feel mum is safe in their care", "The supervisor is very approachable and professional" and "Staff are courteous, friendly and don't rush. They take their time, which is a lot more comfortable [for the person]."
• The service received very positive reviews on a popular domiciliary care review website. All 15 published responses rated the service the highest possible score ("excellent"). Comments included, "I am very satisfied with all care given in my home" and "We are so pleased with Caremark. The carers are so polite and caring and have my husband's best interest at heart. The duty manager is always responsive when we need help or have any questions."
• We saw the service recorded compliments about care workers, carried out an annual survey with people and their relatives and encouraged families to comment on the review website.
• The service also made at least three telephone checks with people or relatives a year to assess satisfaction.

Supporting people to express their views and be involved in making decisions about their care:
• People we contacted confirmed they had originally discussed their care with the service and a 'plan' had been put together.
• Most people confirmed they recalled a review of the plan. All were happy with the care provided and felt their care package matched their expectations and agreement with the service.
• Most of the people confirmed that the service called by telephone or undertook a visit to review the care plan and to ask if they were happy with their care.
• Without exception, people felt able to talk to staff about any changes to the way they wanted to be supported and their individual likes and dislikes.
• People confirmed they were partners in their care, encouraged by staff to be as independent as possible during support calls and always asked to participate in aspects of care.
• People described communication as good; they said the care workers responded to their wishes or requests and where the management were involved, they responded to any call back request or concerns promptly.
• Everyone we spoke with said that they felt able to talk with the staff at the service, who were accessible

when they needed.

Respecting and promoting people's privacy, dignity and independence:
• Staff we spoke with showed genuine concern for people and were keen to ensure people's rights were upheld and that they were not discriminated against in any way.
• People's right to privacy and confidentiality was respected.
• People stated that staff were caring and treated them with dignity.
• Several examples were given to us regarding sensitivity and empathy towards people. For example, one person's spouse said that the care workers were particularly gentle and caring. They said staff were particular about the person's personal care, provided constant reassurance and worked to the person's pace.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs.

People's needs were met through good organisation and delivery of care.

The provision of accessible information:
All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.

• The care records documented that the service identified and recorded communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it.
• Some people had very complex needs, and staff recognised the need for alternative methods of communication with them.
• Care documentation explained what communication aids such as glasses, hearing aids or technology people required as part of their daily lives.
• We saw an example of where care workers were asked to observe a person's facial expressions to see how they were feeling. The person was unable to communicate verbally. This was a good example of using alternative methods for communication.

Personalised care:
• People and families told us care was person-centred and responsive. Comments included, "Efficient and excellent staff", "Excellent", "Consistently good care" and "A dedicated and caring [service]".
• People's feedback about the care approach was gathered in surveys and telephone calls.
• We saw that care plans were reviewed once a year, but more often if needs changed. We saw one plan where the person initially needed help preparing meals but as their mobility had declined the care plan and number of visits had changed to provide more support.
• The person had assessments in October 2017, January 2018, March 2018 and November 2018 in response to changing needs, and moved from requiring a little support with cooking to needing all meals prepared. Visits increased from three to four a day; the medication had changed from self-administration to staff-administered medication.
• Records showed care workers mostly completed their tasks within the allocated time for visits and recorded this. However, there was rarely records of people's moods, emotions or feelings.
• Records focused on the completion of tasks, although the care was person centred. For example, a person's file stated, "[The person] was in the sitting room watching TV" and another recorded, "The person] was in bed when I arrived".
• We provided feedback to the management team about this as part of our inspection. They agreed to review the documentation recorded by care workers.
• Care workers we interviewed recognised that the people they looked after did not have many visitors, so tried to socialise with the person.

• Sometimes it was possible for the service to match a care worker who spoke the same language as a person who used the service. Some people did not speak English and communication was mainly by gestures, symbols and pictures.
• We noted that the electronic care recording meant that there was no longer a record in people's homes of care given. Staff said they could send a printout weekly or monthly to the person or their relative.

Improving care quality in response to complaints or concerns:
• People's feedback, concerns, complaints and compliments were recorded. There were limited complaints and more evidence of positive feedback. This showed people and relatives were satisfied with the service and the support provided.
• The service's phone number was in large print on all the leaflets so people and their family knew who to contact if they wanted to provide feedback or ask questions.
• There was a satisfactory complaints policy dated May 2018. It was written in plain language and people had a copy in their home. There had been no written complaints in the past year.
• One relative had telephoned three times to say their family member had not liked a particular care worker (a different staff member on each occasion). They said the lack of rapport had meant the person had not cooperated with their care.
• The calls had been recorded appropriately in the complaints file and the service had taken action. The relevant care workers had been taken off the rota for the person's care package.
• Care workers understood the need to establish rapport with people. One care worker we spoke with had been verbally abused by a person and it made them feel uncomfortable. The staff member spoke with the supervisor, who changed the rota accordingly.
• Compliments were recorded, whether written or by telephone and the compliment was passed on to the relevant care worker.
• There was no example of a written complaint that needed detailed investigation. However, the supervisor mentioned an investigation in the past where action was taken to protect a person from harm. The service had provided more training to care workers as a result.
• The electronic care system was responsive to people's and relatives' needs, as office staff could review information recorded and respond to concerns more quickly than when they had to wait for records to come back to the office.
• The service had a quality manager who reviewed complaints management quarterly.

End of life care and support:
• We saw an example of an advance directive about care on one client file. However, the service was not involved in initiating such conversations with people and their families.
• There were previous examples of people receiving dignified, pain-free palliative care. At the time of our inspection, one person received end of life care.
• Care plans recorded if a person had a 'do not resuscitate' document. These were kept in the files in people's homes, so they were accessible to emergency services.
• There was no training for staff on end of life care. We provided this feedback to the nominated individual to consider for future staff training sessions.
• Staff said they were advised to maintain a professional distance from people, and this would help them when someone passed away.

Good

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care, supported learning and innovation and promoted an open, fair culture.

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support, and how the provider understands and acts on duty of candour responsibility when things go wrong:
• People and their families described how they felt the agency was well run and responsive to their concerns and needs. Two people confirmed when staff had not met their expectations, the service arranged for a change of staff promptly and without hesitation.
• We spoke with the field care supervisor about their role in ensuring high quality care to people who used the service. They explained that liked their role as it helped to improve aspects of care people received.
• The role entailed engagement with people who use the service and employees. Additional tasks included meetings with social workers to increase people's number of the care hours and liaison with occupational therapists for necessary equipment.
• The field care supervisor also dealt with any issues that relatives raised. They could identify any deterioration in people's health and offer training to staff, for example in advanced dementia care. They said, "I go out to look for issues with quality, and try and 'fix' things up."
• The field care supervisor also explained their role in promotion of care continuity. They said, "If a person gets on with a particular care worker, I will speak with the coordinator to see if the person can have that care worker consistently."
• The management team completed 'spot' checks of staff members, speaking with care workers at people's support calls and provided advice on better ways of working. The field care supervisor said, "This is a managerial role and I have to be firm but approachable [to staff]."
• Staff told us they valued the reviews of the care they provided to people and were receptive to any feedback about how to improve or make necessary changes.
• The management team explained the strengths of the service. They said the team were, "Approachable, with an open door and staff [could] come in and chat to anybody. There [was] good quality of care [and] good care workers employed ."
• The service had identified their own areas for improvement. The main aspect which required further intense effort was recruitment processes. The management team explained the lack of quality of applicants. They had commenced exploring alternative methods of sourcing new staff such as attending job fairs and providing different incentives to attract new applicants.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• The registered manager was on leave at the time of our inspection. The nominated individual managed the regulated activity whilst the registered manager was away. The staff's opinion of the registered manager was complimentary and positive.

• The absence of the registered manager had no impact on the operational function of the service. A staff member said, "No one ever turns around and says 'No, that is not my job'. I heard that a lot in my other role [at a different employer]."
• Another staff member told us, "I worked for a different company before. I love it coming here. It is like a family. The 'higher' management are available and I could speak to them at 9 o'clock at night if needed. I think it is really well-managed. They definitely look after their staff and are always there for them."
• Managerial meetings were held each week between the provider and the registered manager (or nominated individual) and included discussion about staff training, incidents and accidents, safeguarding, new 'clients' and the growth of the service. However, minutes or notes of the meeting were not recorded.
• We spoke with the nominated individual about note-taking at meetings. They were receptive of our feedback and provided assurance that minutes would be taken at all future meetings.
• The registered manager had also held meetings with the care coordinators, field care supervisor and the care quality leader. Operational matters were discussed. The content of the discussions focused on problem solving, ensuring people's care was safe and effective and reviewing any changes needed to care packages.
• A person who used the service said, "I have no hesitation in highly recommending Caremark. I am very pleased with the service I get. All the carers show that extra degree of care and concern, which can be very comforting. They quickly adapted to meet my particular times and needs."

Engaging and involving people using the service, the public and staff:
• The service completed annual staff surveys to gauge the staff satisfaction, strengths and area for improvement. There was a survey in 2017 and 2018 and the service had analysed the results for 2018.
• Themes included having sufficient travel time between people's care calls, the provision of introductory visits to new people receiving care and being kept up to date about changes in people's needs.
• The service had recorded steps to explain the results of the 2018 survey, although they had not created an action plan which showed dates for review, completion or the responsible staff member. We provided this feedback to the nominated individual who was receptive of our suggestion.
• One staff member commented, "Our company has made some changes and we have a new care manager. I am very happy and confident with our new care manager. I am sure that [they] can help and support me in any matter or problem. Certainly, any employee is treated with respect and equality by our new care manager."
• Staff meetings were held about every quarter. An agenda of important topics was included in advance of the meeting.
• The last staff meeting was held in October 2018. Topics included medicines charts, electronic care records, professional boundaries, the availability of management on call, learning from prior incidents, pressure area care and appreciation of care workers' contributions.
• There was recognition of staff members hard work with coffee shop vouchers. These were given out by supervisors as a reward to staff who had 'gone the extra mile'.
• Staff could provide any feedback and discuss any challenges they had in their day-to-day role with supervisors or managers. Staff we spoke with told us they felt comfortable approaching management with any matters.

Continuous learning and improving care:
• A small selection of audits and checks were completed to ensure the safety and quality of people's care.
• A "client file inspection" was completed. The audit focused on 10 different areas of the care documentation. For example, topics included whether there was an accurate needs assessment completed and present in the care file, whether staff had signed relevant records, whether medicines risk assessments and support plans were present and if financial records were completed.
• Three people's files were checked at each audit, and the service worked through all the files over a series of months.

• Staff had spot checks to ensure that their delivery and provision of care was safe and of a good standard. Areas covered included timekeeping, health and safety, professional conduct, documents, record keeping and monitoring.
• One staff member's spot check record stated, "[Staff member] had a good approach to [the person] and his care needs." Comments from the person who used the service was that they were satisfied with the care.
• During another staff member's spot check, the person who used the service stated, "[The care worker] is really nice and does everything I need them to do."
• Telephone monitoring of people's care was completed by office staff within one week of the care package commencing and every six months thereafter. Staff questions people about the responsiveness of the care, the expectations of the person, whether the care was kind and compassionate and support worker satisfaction. The service checked what was working well and not so well. For example, one person wanted a different care worker to provide the care and this was organised by the office staff.

Working in partnership with others:
• The service had good connections with other health and social care professionals to ensure people received the right care.
• The service was also able to liaise with another nearby branch of the domiciliary care group. This was important when there were questions or queries about the operation of the service and when sharing best practice or changes to care provision.
• When necessary, the service connected with GPs and hospitals to ensure people's health needs were appropriately managed and that any changes were made to their care packages. This ensured people received care which was flexible to their needs.