Taylor Grace Ltd

Caremark (Worthing)

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on the 7 and the 13 February 2017 and it was announced.

Caremark (Worthing) is a domiciliary care agency, which provides personal care to people living in their own houses or flats in the community. The registered office is in Worthing however the service provides personal care to people across West Sussex including Worthing, Shoreham-By-Sea and Arundel. It provides a service to older people, people living with dementia, people with a physical disability, people with a learning disability, those with a sensory impairment, younger adults and children. At the time of our visit, they were supporting 110 people with personal care.

The service had a registered manager in post. 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 last inspection on 5 January 2016, we identified three breaches of Regulations associated with gaps in risk assessments and care plans, how medicines were managed, staff supervision and appraisal, how staff were deployed to meet people's needs and how the provider monitored the quality of care provided to people. A recommendation was also made in relation to improving how the provider routinely recorded concerns and complaints. Following the last inspection, the provider wrote to us to confirm that they had addressed these issues. At this visit, we found that the actions had been completed and the provider had now met all the legal requirements.

The last inspection noted significant gaps in people's Medication Administration Records (MAR). This was in breach of Regulation 12 Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection, we found improvements had been made and this Regulation was now met. We received numerous compliments from people (and their relatives) sharing they were happy with how the service supported them with their medicines. At this inspection we identified there was a delay in daily notes and MARs being delivered to the office from people's homes which could delay timely quality monitoring of those records. Due to the issues of significant gaps we found at the previous inspection with MARs; we have discussed this further in the Well-Led section of the report.

We received mixed feedback regarding people receiving calls at their preferred time and how the office communicated with people and their relatives about this and when changes were made to rotas. We discussed this with the registered manager and provider who offered explanations as to why this had been highlighted. We have discussed these issues within the Well-Led section of this report and recommended the provider reviews how they communicate with people and their relatives about what they are able to provide regarding times of care calls and when changes are made to allocated staff.

Accidents and incidents were responded to by staff without delay and the appropriate medical

professionals were contacted for advice and support when required. Staff were able to speak about what action they would take if they had a concern or felt a person was at risk of potential abuse or neglect. The service followed safe recruitment practices. People and their relatives told us they felt Caremark (Worthing) provided a safe service.

People's consent to care and treatment was considered. Staff understood the requirements under the Mental Capacity Act 2005 and about people's capacity to make decisions. Some people received support with food and drink and they made positive comments about staff and the way they met this need. Changes in people's health care needs and their support was reviewed when required. If people required input from other healthcare professionals, this was arranged.

Staff spoke kindly to people and had a caring approach. People spoke positively about the care they received in their own homes. Staff involved people with their care provided and promoted their independence. People were treated with dignity and respect.

People's and relatives views about the quality of the service were obtained informally through discussions with the registered manager and field care supervisors, care reviews, telephone reviews and annual surveys.

At this inspection we found the registered manager open to feedback and enthusiastic about providing a high standard of care to people. The registered manager had introduced systems to promote good practice. Field care supervisors and a recently introduced senior carer role, provided consistency in the delivery of care and an additional link between the office and people being supported in their own homes.

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.

People received safe care and treatment. Staff were trained to recognise the signs of potential abuse and knew what action to take.

Risks to people were identified and assessments drawn up so that staff knew how to care for people safely and mitigate any risks.

There were sufficient numbers of staff and the service followed safe recruitment practices.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

People's care needs were managed effectively by a knowledgeable staff team that were able to meet people's individual needs.

Staff received regular supervision, appraisals and training.

Staff understood how consent to care should be considered.

Some people received support with food and drink and complimented the service on how they supported them with this.
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Staff supported people with their healthcare needs and contacted healthcare professionals when needed.

Is the service caring?

Good

The service was caring.

People were supported by kind, friendly and respectful staff.

People and their relatives were able to express their views and be

actively involved in making decisions about their care.

Staff knew the people they supported and had developed meaningful relationships with them.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

Care records reflected people's assessed needs.

Care plans were personalised.

The service responded to people's experiences. People and their relatives knew who and how to complain to if needed.

Is the service well-led?

Requires Improvement

The service was not always Well-Led.

We have recommended that the provider revisit how they share and communicate information with people and their relatives regarding limitations the service has regarding timings of care calls. This includes when changes are made to rotas.

A range of audit processes were in place to measure the quality of the service provided. However, improvements could be made to the timely monitoring of medicines administration records given previous concerns in this area.

Staff told us that the management were supportive and approachable.

The registered manager was keen to make positive changes to improve the quality of care provided to people.

Caremark (Worthing)

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. We also carried out this inspection to check whether improvements had been made since our January 2016 inspection.

This inspection took place on 7 February and 13 February 2017 and was announced. This inspection used the standard CQC assessment and ratings framework for community adult social care services, but included testing some new and improved methods for inspecting adult social care community services. The new and improved methods are designed to involve people more in the inspection, and to better reflect their experiences of the service. This included giving one weeks' notice so the provider could organise for the inspector to shadow staff making care calls and visit people in their own homes; as it is a domiciliary service we needed to be sure that someone would be in.

The inspection was carried out by one inspector and two expert-by-experiences. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Both had experience of dementia care, domiciliary services and other care environments.

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 reviewed the PIR, the previous inspection report and other information we held about the service. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. In addition the Care Quality Commission had sent questionnaires to people using the service to gain their views on the care they received from the service. We reviewed 16 questionnaire responses from people, 15 responses from staff, four responses from people's relatives and four responses from a community health and social care professional. We used all this information to help us decide which areas to focus on during our inspection.

On the first day of our inspection, we shadowed a staff member whilst they made care visits to three people

in their own homes. We met an additional staff member on one of the visits where we observed staff support a person to move safely. We observed how people were supported by staff and we looked at their daily files. We were also able to chat with people and one relative during the visits. We visited the registered office where we met separately with a field care supervisor and two other care staff to gain their views on the service and the way people are supported. We also met with the registered manager, the deputy manager and the provider. The experts-by-experience spoke with 19 people over the telephone who used the service and nine relatives to gain their views on the care and support they received.

At the registered office we spent time looking at three care records, medication administration records (MAR), complaints, accidents and incidents records, surveys and other records relating to the management of the service. We read three staff records, this included staff recruitment documents, training, staff memos, staff meetings, supervisions and appraisals.

Good

Is the service safe?

Our findings

A risk assessment is a document used by staff that highlights a potential risk, the level of risk and details what reasonable measures and steps a provider is taking to minimise the risk to people they support. At the inspection in January 2016, the provider was in breach of a Regulation associated with risk assessment and management. We found risk assessments were not always accurate and complete therefore potentially placing people at risk. The provider took action and sent us an action plan to inform us how areas of risk were being managed to reduce the impact on people. At this inspection, we found improvements had been made. Risks to people were managed so that they were protected from harm. Risk assessments provided information, advice and guidance to staff on how to manage and mitigate people's risks. Risk assessments covered areas such as how to support people to move safely, skin integrity, how to administer medicines safely and how to support people with the food and fluids they required. When potential risks had been highlighted for people, the necessary guidance was provided in the person's care record. We found risk assessments were updated and reviewed early or sooner if needed and captured any changes. Therefore, this regulation was now met. A field care supervisor told us they were involved in writing risk assessments and said, "The risk assessment checklist highlights where the risks are and prompts you".

At the last inspection, the provider was in breach of a Regulation associated with providing sufficient numbers of staff and how they were deployed to meet the assessed needs of people to keep them safe. Shortly after the inspection, the provider sent us an action plan detailing the improvements they had made. At this inspection people and their relatives told us there were sufficient numbers of suitable staff to keep them safe and the records we checked reflected this therefore this regulation was now met. For example, the provider took action to ensure people who required the support of two staff to support them to move safely were allocated correctly on the rota. One person told us, "They always stay for the allocated time as I always check what time they arrive and leave". Another person said, "Don't always see the same person if they're ill but they always ring to check if it's OK to send someone else". A third person said, "Near enough arrive on time – 5 or 10 minutes late that's all". A relative who was very happy with the timings of the calls told us, "[Named person is very safe with them and that relieves the pressure on me". Another relative told us, "You can set your clock by [named staff member]". A third relative said, "Yes I think there are enough staff. They not only help [named person] but me too. They are an enormous help to me".

The service offered different time periods to people using the service when staff would be expected to attend a care visit. For example, breakfast morning calls would be between 7am and 10am and evening calls were offered between 7pm and 10pm. However, some people and relatives shared their frustrations with regards to the timings of some care calls and the lack of communication from the office surrounding this. Some people told us staff did not always arrive at their preferred time of choice albeit earlier or later than they wanted. We fed back these comments to the registered manager and provider for their review. Whilst this did not seem to impact on the safety of people we have referred to it further in the Well-Led section of this report.

At the last inspection, we found the provider to be in breach of a Regulation associated with the way the service managed medicines. We found significant gaps in Medication Administration Records (MAR) which

meant the provider was unable to demonstrate how people had received their medicines as prescribed. The provider sent us an action plan to inform us of the improvements they had made. At this inspection, we received numerous comments from people and their relatives stating they were happy with the support they received with their medicines. Records we sampled in people's homes did not contain significant gaps therefore this Regulation was now met. One person said, "I have blister packs. They always check and monitor that I've taken it". Another person told us, "They get my medication out for me and then remind me to take it". One relative told us, "They handle all [named person's] medication and [named person] gets it regularly and they always fill out the sheet".

We observed a staff member administer oral medicines to one person in their own home; they were confident and sensitive in their approach and waited for the person to swallow their medicines. We noted they signed the MAR prior to the person taking their tablets. Even though the staff member was vigilant and checked the MAR again after the person had swallowed their medicines this was not in line with best practice and the service's own medicine policy and procedure and training guidance. We discussed this with the staff member and the registered manager and felt assured this practice would be amended. We also observed the same staff member apply cream to another person's legs. They knelt down in front of the person whilst doing so talking to them throughout the task to ensure the person was involved in what was happening to them.

We were told and records confirmed, staff were observed administering medicines during spot checks by a field care supervisor to assess the competencies of the staff team. Memos were also frequently sent to staff from the office with reminders regarding the correct medicine procedure to ensure risks to people were minimised and staff knew what to do if they were concerned. Staff could relay the correct medicine administration procedure and told us they had no concerns with regard to how medicines were administered to people. Staff told us they valued the training and support they received from the office. A field care supervisor told us, "Carers are very good at picking up any issues (with medicines) and letting us know about them". During this inspection we identified there was a delay in MARs being delivered to the office from people's homes and not all MARs were audited by the office to check for any errors or issues. These were checked in the community by field care supervisors during their own quality assurance visits however due to the previous issues we have discussed this further in the Well-Led section of the report.

People confirmed they felt safe when staff were in their own homes and we observed people looked at ease with the staff who were supporting them. One person spoke positively about the care they received and said, "I feel very safe with them. I'm not safe showering without them here". Another person said, "I definitely feel safe with them (staff). A third person said, "I do feel safe. I keep my door locked and they ring to say they are here so I can open it for them". A relative told us, "The carers keep him safe by walking behind him when he is using his walking frame, in case he falls".

Staff had been trained to recognise the signs of potential abuse and in safeguarding adults at risk. Staff explained how they would keep people safe. They could name different types of abuse and what action they would take if they saw anything that concerned them. All staff told us that they would go to the registered manager and others in the office in the first instance and failing that would refer to the whistleblowing policy for advice and guidance.

We observed staff support a person to move safely during our inspection. Staff told us and records confirmed, the training they had received in moving and handling safe techniques including the use of hoists and standing aids. Staff used equipment cautiously and offered reassurance to the person who may have felt vulnerable whilst transferring from a wheelchair to an armchair using an overhead hoist.

Accidents and incidents were reported appropriately. Documents showed the action that had been taken afterwards by the staff team and the registered manager to help minimise the risk of future incidents or injury to people.

Staff recruitment practices were robust and thorough. Applicants completed an application form which were reviewed by office management to establish whether they were suitable to be shortlisted for an interview. Applicants were interviewed by two or more senior staff and asked a series of questions related to the role of a health and social care worker and how they would respond in various situations. It was also an opportunity for the provider to establish the knowledge, skills and experience of each applicant. Staff were only able to commence employment after and upon the office staff receiving two satisfactory references, including checks with previous employers. In addition, staff held a current Disclosure and Barring Service (DBS) check. The DBS provides criminal record checks and helps employers make safer recruitment decisions. Successful applicants attended a thorough induction and shadowed more experienced staff prior to working alone supporting people in their own homes. Please see the Effective section of this report where we have referred to the training and support staff had received.

Good

Is the service effective?

Our findings

At the last inspection, in January 2016 we found the provider was in breach of a Regulation associated with the support staff received. We had identified there was a lack of supervision and appraisal opportunities provided to the staff team. Shortly after the inspection, the provider sent us a plan, which told us the actions they were taking. At this inspection, our observations and records sampled confirmed people received effective care from staff who had the skills and knowledge they needed to carry out their roles and responsibilities therefore this Regulation was now met. We asked people if they found staff to be well trained and competent. One person said, "Oh yes definitely". Another person said they were, "Very happy with the service". A third person told us, "They help me a lot, so yes I do". A fourth person said, "They have got a good bunch".

People received support from staff who had been taken through a thorough induction process and attended training with regular updates. All new staff attended an induction, which included moving and handling, safeguarding adults and medication training. This was followed by shadowing more experienced carers. One person told us, "When a new one starts they shadow an experienced one for a while". A new staff member told us, "I did a bit more shadowing as I was new to care". The induction incorporated the Care Certificate (Skills for Care). The Care Certificate is a work based achievement aimed at staff that are new to working in the health and social care field. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment.

The induction period also included competency assessments to ensure staff were ready to undertake their care duties in the community. In addition to the training provided, the supervisor carried out unannounced 'spot check' visits on all staff approximately every six weeks. The field care supervisor was responsible for supporting staff in the community and providing a link between care staff and the office. Since the last inspection, the service had also introduced a senior care role to provide additional support for care staff working in the community. During spot checks the field care supervisor observed how the staff member carried out their role and responsibilities on that particular care visit. The registered manager told us staff meetings were more difficult to arrange due to staff and their commitments to care visits and personal circumstances. However, two staff meetings had taken place since March 2016. This was an opportunity for staff to come together and discuss work related issues. The service employed two field care supervisors who were split into two geographical areas across West Sussex to enhance communication flow between people and the office and provide the necessary support to care staff. They were also able to step in and cover care calls if staff were absent or an additional need arose.

Some staff had completed a National Vocational Qualification or were working towards various levels of Health and Social Care Diplomas. These are work based awards that are achieved through assessment and training. To achieve these qualifications, candidates must prove that they have the ability and competence to carry out their job to the required standard. For example, a field care supervisor we spoke with had achieved a level three Health and Social Care Diploma.

Staff complimented the training and support provided from the management team. A staff member who

started working for the service in November 2016 told us, "All the carers seem lovely, staff are really helpful ". Another member of staff said, "Supervision is frequent and we have an appraisal once a year". Mostly people spoke positively about staff however one person told us, "The new staff are not well trained". Another person said, "The older staff have more of an understanding". A third person said, "They need training around understanding of illnesses". Shortly after the inspection we fed back some of the comments to the registered manager who responded with, 'Brand new, inexperienced staff may initially lack the full confidence of a more experienced carer and this may perhaps show through at first. However they are all fully trained to do their job safely and effectively.' They also added, 'Customer choice is paramount in all cases. If they are not happy to have any particular member of staff within their home they will not be sent there'. The field care supervisor told us, "New staff members can't go out (to support people) until they have done their training and at least three shadow shifts". They also told us, "I get such good feedback about the carers, we have such good carers".

People were involved in making decisions which related to their care and treatment. When we visited people's homes, we saw people were offered choices by staff. Consent to care and treatment was sought in line with legislation and guidance and this was reflected in care records. 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 MCA 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. Best interest decisions made on behalf of people who lacked capacity were made by health and social care professionals, the registered manager and team and the relevant family members.

Staff received training on the topic and understood how consent should be considered. They told us most people they supported had capacity to make decisions about their daily care needs. A field care supervisor told us they were able to assess people's capacity in the initial stages. They said, "We ask care staff to tell us or point out when a person is finding something difficult and I will go back and reassess them".

People were assessed to identify the support they required with food and drink and care records reflected this. Nutritional assessments were carried out and staff completed various documents relevant to the individual support, which had been provided on each care visit. People spoke positively about the support they received from staff with their meals. One person told us, "Yes they do all my meals for me, no problem at all". Another person told us, "They do my lunch and my daughter shops for me, so I choose what I want". A third person told us, "My neighbour does my shopping and the carers get my lunch ready". A fourth person told us, "Yes they get my breakfast no problems at all". We observed a staff member ask, "Are you ready for your breakfast now?" The person was offered a choice of what to have and when the cereal chosen was given the staff member delicately placed a serviette on the person's clothing to protect it.

People felt confident that staff could manage their healthcare needs if needed. The support provided would vary depending on a person's needs; some people or their relatives were able to book and attend their own health appointments. One person told us, "If I get any Doctor's or hospital appointment, I let the office know and they arrange my appointments to fit them in". Where healthcare professionals were involved in people's lives, this care was documented in their care plan. For example, we noted that GP's and district nurses were involved with some people's care. Staff informed the office of any concerns and documented any changes in people's daily files which highlighted the issue to the next staff member on the next care visit. Another person told us, "One time when [named staff member] arrived I had shortness of breath and chest pains. She contacted the Doctor and arranged for him to come and I ended up going straight to hospital in an ambulance".

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. We observed staff supporting people using a caring approach and they were patient and kind. Staff used appropriate light levels of humour, which seemed to lift the spirits of people they were providing supporting whilst personal care tasks were being carried out. We received numerous comments from people and relatives regarding how caring the staff were. One person told us, "What they do for me is just beyond the pale. They're just marvellous". Another person said the staff were, "Angels from heaven". A third person said, "They are warm and helpful". A relative told us, They chat to [named person] all the time. They even sit on [named person's] bed chatting whilst they're filling in the book". A fifth person said, "They explain things to me". However one person said, "They are, by and large, pretty caring. It does vary sometimes who comes. Another person said, "Most of the time they are caring I think some are dedicated to the job, but the younger ones not so much".

People were encouraged to be involved with their care and to remain as independent as possible. We observed staff chatting with people about what was important and relevant to them and explaining what they were about to do. One staff member brought a framed photograph closer to one person so they could explain to us who was in the picture which happened to be a valued family member. The staff member knew who the person in the photograph was which meant a meaningful relationship had developed between the staff member and the person. We also observed another person having their hair gently brushed by a staff member who knew exactly how they liked it brushed. The person was not well at the time of our visit however seemed to enjoy it. People and relatives told us they felt included in decisions about their care including choices about what to eat, what to wear and where they wanted to move to within their own homes. "We agreed a plan in the beginning, yes I was involved". One person told us how they appreciated the support they received from the staff. They enjoyed being able to complete some tasks alone they said, "They're very respectful with the bathroom stuff. I do it myself with the door slightly ajar. They always have two warm towels waiting for me". Another person told us, "They help me to wash, well more supervise me. They're very respectful".

People we visited were aware of the contents of their daily care files and were happy for us to read them as part of the inspection. These included contact information, their care plan and other daily monitoring forms pertinent to the individual. People and if necessary their relatives, were encouraged where possible to sign documents within their files which showed they were involved with the care they received. People told us they were given opportunities to make comments about the service and review their own care and support. Field care supervisors, deputy manager and registered manager were involved in holding reviews with people and their relatives and if necessary. This opportunity aimed to ensure people were happy with the care they received and any issues were dealt with effectively and promptly.

People told us staff respected their privacy and promoted their dignity whilst supporting them with their care and we observed this in practice. One person said, "They're very discrete with showering. I feel very comfortable with them". Another person said, "They're very respectful". A relative told us, "[Named person] doesn't want female carers doing intimate stuff so a male carer showers him and makes him feel very comfortable". Staff used the appropriate tone and pitch of voice and crouched down to a person's eye level

when they were talking with them and providing personal care. Staff were sensitive with regard to being in a person's own home and were mindful about people and their relative's property. However, one person told us some staff were not as good at clearing up after themselves as others. Staff knocked on doors before entering and closed them when providing personal care to people. One staff member told us, "We show respect it is how I would like to be treated". At a team meeting in November 2016 the registered manager had reinforced how important it was to pick up on the mood of a person during a care visit and alert any concerns (in addition to health issues) about how they presented to the field care supervisor. This meant a caring practice was embedded throughout the organisation and people's well-being was considered as part of staff's role and responsibilities.

Good

Is the service responsive?

Our findings

At the last inspection, we found the provider was in breach of a Regulation associated with care records. We had identified some care plans lacked accuracy, were incomplete and did not provide the necessary guidance for staff supporting people in the community. Shortly after the inspection, the provider sent us a plan of the action they were taking to make improvements. At this inspection, we found improvements and actions had been taken by the provider to ensure care plans were personalised, fully completed and regularly reviewed on behalf of people using the service. Care plans were fit for purpose, reflected information relevant to each individual and their abilities; including people's communication and emotional and physical health needs therefore this regulation was now met. One relative told us, "The Caremark manager was brilliant at [named persons] initial assessment".

Each person had a care record which included a care plan, risk assessments and other information relevant to the person they had been written about. Care plans were personalised and reviewed every three to six months or sooner if required. They included information provided at the point of assessment to present day needs. The care plans we read provided staff with detailed guidance on people's histories, how to manage people's physical and/or emotional needs, their goals and their aspirations. This included guidance on areas such as communication needs, continence needs and mobility needs. Care plans were wrote in the first person and provided a detailed breakdown of routine each person required for each care visit they received. For example one person's care plan read, 'I would like carers to assist with my personal care routine and cream my arms and legs'. The care plan also stated the person's long term goal was to, 'Continue living in my own home with the assistance of carers', and added, 'I do not like things being moved in my own home'. The person had also requested during the evening call staff needed to, 'Take my body warmer off and put on my bed jacket'. We observed staff knew people well and used the daily care file whilst providing support to people to ensure they were aware of any changes and recorded any tasks they had carried out and how the person had presented.

Our observations and records we read concluded people received a personalised service and staff had the necessary guidance to refer to during a care visit to ensure people's assessed needs were met. However, one care staff told us the level of detail was not always available in care plans and there was a need for the service to improve on this. We also received a few comments from people using the service who were unsure whether they had a care plan in place. We discussed this with a field care supervisor and the registered manager who were involved in carrying out new assessments with people and implementing care plans for their review. The registered manager spoke passionately about the improvements they had made to care plans and the interaction they had had with people they supported and was keen to identify what if any gaps remained and rectify the issue. A field care supervisor who had been working for the service for one year told us, "Paperwork has improved" and shared how proud they were as they had managed to review all care plans with people in their geographical patch. A new member of staff told us, "Care plans are pretty good. Sometimes the details might be out of date. We let the office know and they do something about it".

At the last inspection, we made a recommendation to the provider to review its systems for recording the

outcomes, actions and learning with regards to complaints received including how they fed back to people. At this inspection we were able to check the complaints log and found improvements had been made and all the necessary information was recorded when responding to concerns and complaints from people. There was an accessible complaints policy kept in people's daily files, however there were no open complaints at the time of our inspection. People and their relatives told us they knew they could approach staff members, field care supervisors and the management team if they needed to. One person told us, "We have never had reason to complain but would if need be". Another person said, "I have nothing to complain about really". A third person said, "No complaints, they're very flexible". A fourth person told us, "Any problems are dealt with". A relative told us, "I have complained in the past about carers being late but it does seem to have improved lately". Mostly, people seemed happy with their care however, some people complained they did not receive care at their preferred time and this influenced their views on the service provided by the office. We have referred to this in the Well-Led section of the inspection report.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, we found the provider in breach of a Regulation associated with how the service monitored and improved the quality and safety of the service for people. Audits carried out by the management team had failed to ensure improvements had been made to such areas as how medicines were administered to people, supervisions for staff, how staff were deployed, gaps in care plans and risk assessments and how complaints were managed. Shortly after the inspection, the provider sent us a plan of the actions they were taking to ensure improvements were made. At this inspection, we found improvements had been made to all areas impacting the delivery of care and we have made reference to this throughout the inspection report. As a result, the service had improved from a 'requires improvement' to 'good' overall and legal requirements were met.

Audits were now carried out by field care supervisors to ensure the quality of care provided to people. This included checks on people's daily completed records. These were carried out directly with people and their relatives in the community within their own homes therefore this Regulation was now met. One person told us, "I can't speak about Caremark highly enough, I recommend them all the time". Another person said, "The management are very helpful".

The service had sent out 100 annual satisfaction survey's to people and their relatives in October 2016. Mostly out of the 44 returned, people responded positively and people ticked, they 'agreed' or 'strongly agreed' with statements asked. This included, 'My care and support workers are always professional and helpful' and 'My care and support workers stay for the agreed time'. However, we noted eight people disagreed with the statement, 'My care workers arrive at the agreed time'. Despite the improvements made by the service since the last inspection this seemed to be consistent with some of the feedback we received. As referred to in the Safe and Responsive domains of this report, we received a mixed response regarding whether staff making care calls were on time and whether communication was effective between the office and people. This influenced whether people felt the office was Well-Led. Some people were frustrated with calls being later or earlier than they wanted and the lack of information provided from the office regarding rotas. One person told us, "They are a bit hit and miss with their times, but they have never missed a call". Another person said, "Communication isn't great, sometimes the appointments show as unallocated on the sheet and they don't tell you if there's a change of carer". A third person told us, "There seems to be barriers between the office and carers". A fourth person said, "I would recommend based on the carers but not the admin". A relative told us, "They sometimes come far too early, like 2 hours early. I've mentioned it to the office but it's happened again since".

We fed back this information to the registered manager for their review. They were disappointed with the negative comments. They told us very few care visits were 'locked in' which meant no specific time agreed yet they aimed to provide people what they preferred however not always possible due to the demands on the service. The expectation would be a staff member would make the call between the following time frames. Morning calls could be between 7am-10am, lunchtime calls between 12pm -2pm, teatime calls between 4pm-6pm and evening calls between 7pm and 10pm. Shortly after the inspection the registered manager wrote to us as had considered the feedback and said, 'When taking on packages from WSCC and

the local CCG we are encouraged to offer a more flexible range of call times if it makes the difference between being in a position to take a package on or not'. They added, 'During our own assessment process, desired call times are discussed, however we try to make things clear that these are times that we will strive to achieve as slots become available or availability increases.

The registered manager also shared, 'All care workers are regularly reminded that it is their responsibility to ensure that either the client or the office is notified if they are running late so that the customer is kept informed and does not worry'.

In view of the feedback we received we recommend that the provider review and revisit how they share information with people and their relatives regarding limitations the service has regarding timings of care calls and what realistically can be offered and maintained. This is to ensure communication flow between the office and all people are open and to avoid further anxiety for those receiving care and support.

Whilst checking audit records we identified daily notes and MAR sheets were not being returned to the office by staff consistently. For example, one person's MAR sheets had not been returned to the office for checking by management for eight weeks. We did not observe any negative impact on people due to the length of time noted and field care supervisors carried out routine checks on daily notes and MAR within people's homes. However, it may mean errors in medicine administration may go unnoticed by the office team and delay remedial actions. Due to the level of significant gaps we found at the last inspection we highlighted this to the registered manager. By the end of our inspection, the registered manager had discussed this with her office colleagues including the deputy manager, to establish ways of how to improve the speed of how information was returned to the office for their review so any concerns did not get missed.

Staff spoke positively about their work, felt the service was managed well and understood their role and responsibilities. One staff member said, "I am really happy with the company no issues at all". The registered manager spoke about initiatives she had introduced to try and promote motivation amongst the staff team. This included 'carer of the month' and a monthly newsletter. A new staff member had received many compliments from people and their relatives so had achieved the latest carer of the month award which included being presented with a certificate and a bunch of flowers.

The registered manager remained passionate about providing good care to people in their own homes. She was open throughout the inspection and remained proactive when addressing areas, which may require further improvement including sending the Commission documents to support any changes made. The registered manager also shared an office and worked alongside the company's recruitment manager, deputy manager and care coordinator who worked as a team to support people receiving care from the service. The provider wrote to us shortly after the inspection and said, 'I have felt that we had taken on board and learned much from the outcomes reported from the last inspection. This has been a very positive process focusing on producing a service with processes in place which would highlight any shortfalls before they become a problem'.