SOS Homecare Ltd

SOS Homecare Halton Service

Inspection report

Suite 2, Ground Floor, Orange Zone, Halton 5,
Halton Lea, Runcorn, Cheshire,WA7 4HF
Tel: 01928 890498
Website: www.soshomecare.co.uk

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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?	Requires improvement
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 21 July, 10 August and 3 September 2015. The provider was given 24 hours' notice on the first and third days because the location provides a domiciliary care service and we needed to be sure that someone was available in the office as well as giving notice to people who used the service that we would like to visit them at home.

This was the first inspection of SOS Homecare Halton Service since it registered with the Care Quality Commission (CQC) in 2014. At the time of the inspection the provider was supporting 24 people with personal care in their own homes. The majority of people who used the service were older people. Most of the service was provided on the basis of a commission by Halton Borough Council.

There has been a registered manager at SOS Homecare Halton Service continuously throughout its registration with the CQC. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager had recently changed in August 2015 just before our inspection.

We found breaches of Regulations relating to medicines, safe care and treatment and governance. Medicines were not always administered safely, we could not be satisfied that people had received the care planned for them and records were not always kept accurately. You can see what action we told the provider to take at the back of the full version of the report.

We found that the service provided by SOS Homecare Halton Service required improvement in all the areas we looked at. In addition to the breaches of regulations, people who used the service did not feel that they were always informed if staff were not going to attend on time as agreed. Quality assurance systems had not delivered the improvements which they identified were required.

People who used the service felt safe and staff were checked as suitable for their role, inducted into it and then trained so they could do their jobs. People who used the service liked the staff and were complimentary about them. Care plan documentation was easy to understand and was designed around the needs of people who used the service. Management had access to good information available about the service and had implemented some communication systems such as staff meetings and supervision.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was not always safe. The management and administration of medicines was not always safe. Records did not demonstrate that medicines had always been given in accordance with their prescription.

People told us that they felt that the service provided by SOS Homecare Halton Service was safe. Staff knew what to do if they were concerned about something such as abuse. The registered provider operated safe recruitment procedures.

Requires improvement

Is the service effective?

The service was not always effective. Arrangements for people to consent to their own care were not always clear. The arrangements for people who did not have the capacity to consent to their own care did not conform to the legislation and regulations regarding this.

Staff were well-trained and there was a comprehensive system of induction so that staff could learn what was required of them in their role. Staff undertook shadowing of more experienced staff until they felt confident to work alone.

Requires improvement

Is the service caring?

The service was not always caring. We could not be satisfied that the care planned for people had been carried out. Records did not always confirm that actions identified as required in care plans had been completed.

People who used the service and their relatives were generally complimentary about the service provided by SOS Homecare Halton Service and said that they found it caring and friendly.

Requires improvement

Is the service responsive?

The service was not always responsive. Although records showed that timekeeping was generally good some of the people who used the service felt that they needed more notice if staff were going to be late.

Care plan documentation was good and centred around the needs of the person who used the service. Risk assessments we saw were up to date but needed to more closely reflect individual circumstances. We were unable to identify how they had been reviewed.

Requires improvement

Is the service well-led?

The service was not always well-led. Quality assurance systems had identified areas for improvement such as medication but this improvement had failed to materialise.

Requires improvement

Summary of findings

There were good systems for internal and external audit although these had not always directly led to required improvements. The current registered manager had only been in post for a few weeks at the time of our inspection

SOS Homecare Halton Service

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 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.

This inspection took place on 21 July, 10 August and 3 September 2015. We visited service users in their own homes on the first and second days of the inspection.

The provider was given 24 hours' notice on each day when we visited the office because the location provides a domiciliary care service and we needed to be sure that someone was available in the office as well as giving notice to people who used the service that we would like to visit them at home.

The inspection team was made up of two adult social care inspectors on the first day on which one of the inspectors undertook visits to people who used the service in their own homes. The other inspector contacted other people who used the service and visited them in their own home and returned to the office on the second day of the inspection. The inspection team also included 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 in this case services for older people. The expert-by-experience contacted people who used the service in between the inspection days.

The registered provider had sent us a Provider Information Return before the inspection which we reviewed before the inspection together with reports form the local authority which commissioned services from it. We reviewed all this together with information already held by the Care Quality Commission (CQC).

During the inspection we visited three people who used the service and two people who either lived with them or who were their relatives. When we spoke with them we also asked for permission to look at the care records kept in their home. We were invited to visit one other person but they decided they would prefer to speak to us by telephone. The expert-by-experience talked by telephone with eight people who used the service as well as nine relatives. Where a person requested further contact with the CQC an inspector followed this up either in person or by telephone.

During our visits to the office we spoke with the registered manager, operations director, care coordinator and training manager. We spoke with four members of care staff. We looked at four care plans as well as four staff files and reviewed a number of documents including policies and procedures.

Requires improvement

Is the service safe?

Our findings

We asked people who used the service if they found the service provided by SOS Homecare Halton Service to be safe. Everyone we spoke with told us they felt safe using the service.

None of the people we spoke with expressed any concerns about the registered provider's role in respect of their medicines. However we were concerned that there were not always adequate records of medicines administered.

We reviewed medicines administration records (MAR) for two people.

One record referred to the administration of a controlled drug. Staff used the convention of entering "SN" (meaning "see note") on the MAR sheet to cross refer to something written in the log book. However the log book entries were confusing. Sometimes they referred to the medicine not being available. On other occasions they stated the medicines had been given and been seen to be taken by the person. If this was the case then the entry on the MAR form should have been "A" for "administered". Sometimes the "SN" appeared to refer to other medicines entirely. Entries were signed by one member of staff whereas the provider's own medication policy required the administration of controlled drugs to be witnessed by two staff.

In another example we saw that a person had been prescribed two tablets in each dose but the corresponding record showed only one tablet being given. The record of administration suggested that varying doses had been given but no explanation was recorded for this. Where medicines were prescribed "PRN" or as required there were no instructions for staff to follow about when they might or might not offer these if the person was unable to express this for themselves.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not arrange for the proper and safe management of medicines.

The service had a comprehensive, up to date medicines policy. The manager said the competency of staff to manage medicines was checked before they administered any medicines and then again every three months. We saw records that confirmed this. The medicines policy identified two levels of medicines' care where people did not take their own medicines – assisting with medicines and administration of medicines by care staff. The level of support each person required with medicines was detailed in the care plans that we saw. We were told that all staff were trained to administer medicines. Staff said that some people required prompting with medicines but that two of the people we visited both required administration of medicines by care staff.

Each person had a care plan for medicines' administration. It included details of how medicines were ordered and received for them and the safe location of each person's medicines. For one person this was in a secure cupboard and for another it was in a locked safe. One person ordered their own medicines which were delivered by a pharmacy. Another person's medicines were ordered and collected by a relative. Both people told us that staff handed them their medicines and watched until they were taken. One member of staff told us they always did this before recording that medicines had been taken.

We talked with staff and asked them if they knew about the importance of safeguarding people who used the service from abuse. They were able to identify the sorts of abuse which might affect people and identified the correct course of action they would take in informing their manager of any suspicions they might have. One told us "If there is something that is not right, then report it". Staff also correctly identified the circumstances in which they might whistle blow for example if they thought there was something wrong at work and did not feel it was being resolved properly. The provider had a safeguarding and whistleblowing policy both dated February 2015.

We checked that the provider took appropriate safeguards as outlined in the relevant regulations when recruiting staff to work there. We found the personnel records we looked at to be complete including an application form and interview questions which were based around the sorts of scenarios which a member of staff might encounter if they were employed by the provider. We found that references had been taken up so that the provider could verify the work history given by the applicant. We saw that the provider checked the references by making contact with the referees who provided them. Applicants were also asked to undertake a written test so that the provider could

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Is the service safe?

assess their ability to keep records. The provider checked each employee with the Disclosure and Barring Service so that they would know if an applicant had a criminal record and could take action accordingly.

We saw that the provider also asked potential employees if they had any health conditions which might affect them so that the employer could make any appropriate adjustments to take account of these. We saw that all these arrangements were outlined in a current recruitment policy which had been issued in the last six months. We saw detailed audit forms which allowed the registered manager to see at a glance if all the relevant checks were in place as well as if subsequent induction training had been completed.

We asked staff to tell us how they had been recruited to work for the provider and they confirmed the process as described above. They told us they undertook a three day induction and then were allowed to "shadow" another member of staff until they felt confident enough to start working alone. We talked with one member of staff who was undertaking this shadowing and they told us that they were enjoying the process and that it allowed them to get to know people who used the service and how to provide the care they required. We saw that all staff appointments were subject to a three month probationary period.

The provider took a number of measures to safeguard people's overall safety. This included making sure that personal information regarding security arrangements was properly managed and arrangements to be followed if a worker was unable to gain access to someone when this had been previously arranged. The registered provider had established a convention for staff to use if they were in difficulties and could not easily call for help. We saw that the registered provider had a lone workers' policy and that this and other health and safety issues such as relating to moving and handling were covered in the training provided to staff.

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Is the service effective?

Our findings

Most people using the service told us that they felt their needs were met and a good service was provided. Only one person expressed concern about the effectiveness of the care provided. They told us "(The care staff) tell me their task is to make the person comfortable when sitting but they do not do the personal care properly. The agency have not sorted this out". They felt that staff avoided certain tasks either because they were not trained very well or wished to avoid them and added "The care staff are lovely – they are just not trained". We became aware that this was a complex situation with the involvement of other agencies and so, with the person's consent, we referred the matter to the local authority for further investigation and to see if any further assistance could be provided. We wrote to the person and confirmed that we had done this and brought the matter to the attention of the registered manager.

We saw that the SOS Homecare Halton Service had a training and development policy. We saw induction certificates that showed that this included the topics which are considered to be the common induction standards recommended by the appropriate sector skills training body for the care sector. We checked to confirm that this induction included training in safeguarding and whistleblowing as well as other key areas such as moving and handling and infection control. We were provided with a copy of the registered provider's induction policy. We saw that staff were provided with an employee portfolio which included key information about the job, policies and expectations of them. Staff were encouraged to build this as a portfolio to include training certificates and records of their personal development. They told us they could refer to it at home when they needed to.

The standard training programme included annual training in moving and handling, health and safety, fire safety, safeguarding, medicines administration, and the principles and values of care. Staff were also provided with training in food hygiene, first aid, infection control, incontinence and stoma care as well as dementia every two years. We checked the training records for staff and saw that all induction had been completed within the last year since most staff had come in to post for the first time. We saw records of shadowing visits in order to check staff competency. These were checks conducted periodically where a member of staff would be observed. According to the records we saw the observations included person centred care, nutrition, infection control, safeguarding, health and safety and security as well as a check on whether the care worker was appropriately dressed and behaved professionally.

One member of staff told us about an occasion when a person had been unwell. They told us they had acted on their training and the policy of the service and telephoned the office. The registered manager advised contacting the person's GP who told them to call emergency services, which was done. The member of care staff had stayed with the person, supporting and reassuring them, until they had been assessed by a paramedic team. This showed us the service had a policy and procedure which staff knew in order to manage an emergency safely.

We looked at the arrangements for people who needed two staff because this was the only way care could be provided safely for them. We checked the records for three people and found that the care log books had all been signed by both members of staff to show that this requirement had been met. Staff told us that where two members of staff were required it was their practice not to enter the person's home alone so as to avoid a situation where a member of staff might undertake care on their own.

We looked at care plans to see if people had formally consented to their care plans. In some instances we saw that the care plan was signed by the person receiving the service. However in two other instances whilst we were told that people had the capacity to agree to their treatment or in the absence of evidence to the contrary, we saw that consent to their care plans had been signed by other interested persons. We could not understand why these people who used the service had not been asked to consent to their own care plans. If for any reason they did not wish to do so or wished another person to do this on their behalf this could have been recorded.

The Mental Capacity Act 2005 is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions made on their behalf are made in people's best interests. Certain applications to restrict people's liberty must be made to the Court of Protection. No one at SOS Homecare Halton Service required these arrangements.

We saw there was a policy relating to mental capacity and that a section of the care planning document included a

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Is the service effective?

checklist for staff to consult. However because the checklist did not conform directly to the tests required in the relevant regulations we found it hard to determine whether a formal assessment had been made or not. This did not appear to conform to the registered provider's own written policy and procedure on mental capacity which referred staff to the relevant requirements of the legislation.

We asked staff if they prepared meals for any of the people who used the service. They told us that where this was the case it was limited to microwaving meals. Staff were conscious of the need to wear personal protective equipment such as gloves and aprons and confirmed that they did so. We saw that nutrition and food hygiene were included in the induction training programme.

We recommend that the registered provider ensures that the consent of people to their care plans is clearly recorded. Where this is not possible the reasons for this should be clearly noted in the care plan.

We recommend that the registered provider makes arrangements for care plans to include formal assessments of mental capacity which conform more closely to the prescribed requirements for this test and record whether or not any other assessments of mental capacity are in existence e.g. from another agency.

Requires improvement

Is the service caring?

Our findings

When we talked with people who used the service most told us they were happy with the care received and felt they were well looked after. One person told us "Privacy and dignity is respected and staff will talk and ask what you want doing".

Some people said that they really looked forward to care staff visiting with one commenting "They are like family and we have a chat". One relative said "They are caring and compassionate. We look forward to them coming". Another relative told us "They treat my mum with dignity and respect, closing doors and curtains when doing personal care. Another person told us "(The care staff) are helpful and pleasant and will do want you ask them to". People in general liked the care staff who were said to be very nice and helpful.

Only one relative expressed concern at the inconsistency of staff who visited saying ""My relative has dementia so different care staff coming causes difficulties. I have raised this with the office and they have said they will resolve the issue". However two other people said that the same care staff usually came to them and so care was consistent for them.

We checked the care information and log books kept in people's houses against the information kept in the care plans and were concerned that on a number of occasions the two did not correspond. For example we found two references to the need to make sure that a person's Lifeline alarm button was within their reach before the care staff concluded the visit but in the two logs we looked at neither recorded that this had been done on more than a few occasions.

In two instances we found instructions to care staff to check skin integrity because people might be spending a lot of time sitting at home in a single position or might have other illnesses which compromised this. This risk was not noted in the most recent risk assessment for this person. In one instance the instruction was quite specific as to when this check was to take place but when we looked at logs for the last two months there was no evidence of these checks.

This was a further breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not provide care and treatment for people who used the service in a way that mitigated identified risks to them.

In this instance we thought it likely that skin integrity was actually being checked in the context of the other care tasks which were required such as bathing but this was not being explicitly recorded so that trends could be monitored. In the other instance there was no obvious way in which the completion of these checks could be verified.

On other care files we saw references to care staff recording food and fluid intake. This included statements such as "Staff to observe dietary and fluid intake and record on food/fluid chart in every call" and "Staff to encourage fluids and document on food/fluid chart". However although we saw that the provider had a food and drinks pro forma we did not see it in use with the corresponding log books. In one instance staff had logged what a person had drunk but had not included any indications of quantities referring only to "Pop" and "Coffee" rather than recording whether the person had drunk a full can of soft drink or a full cup of coffee or less respectively.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The registered provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to them.

We asked staff how they knew that they were providing the care that people wanted. They told us that the specific tasks for each person were detailed on the "app" they carried on their smartphone which also provided them with their order of calls. One member of staff showed us how this worked. The "app" provided key information about the people who they were due to visit. Staff also told us that they read the care folder in each person's house to find out about what was required and what care other staff had provided as well as reading the care plan in the office. Any important information that needed to be passed on was done by ringing the office. We heard a number of such conversations whilst we visited the office.

The registered manager told us that as a small service which had been established quite recently most of the staff group were known to most of the people using the service.

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Is the service caring?

This included office staff who also made visits. Consequently there was less chance of a person receiving care from someone with whom they were unfamiliar or had not met before. This was borne out when we raised queries during our inspection of care files in the office. Both the registered manager and the administrator were able to answer our queries from their direct experience of the people concerned.

The service had a detailed policy to deal with complaints that referenced that of the local authority. It included a staged procedure including receipt, investigation and response to any complaint.

We looked at the two most recent complaints documented by the service. One in February 2015 had followed the procedure. Another from a couple of months earlier showed only the letter from a member of staff but not details of investigation or follow up. The current registered manager who was new in post was not aware of the details as it had occurred before she worked for the service but thought the procedure had not been followed because it related to concerns of staff rather than a complaint from or on behalf of a person using the service.

We looked at a number of care log books which the provider placed in people's homes for care staff to complete. One relative told us that they thought that they had been told that they should not write in this log book but we saw entries made by another person in their book in which they sent complimentary messages to staff such as "Many thanks to each of you for your care and kindness" and "Thank you for helping me today". This person had also included instructions for staff about how they wished their care to be delivered having written "Please ring the doorbell before entering".

All the central documentation we saw was kept securely in a locked filing cabinet in the office. Care files were only removed when they were required. This meant that people could be reassured that information about them was kept confidential. We saw that the registered provider had a confidentiality policy which included how information was stored and in what circumstances it could be shared with other parties.

The service maintained a record of compliments received about the service they provided. There had been four in the previous year and they included, "Compliments on the standard of care", "Gratitude to care staff" and "Thanking us for care provided".

Requires improvement

Is the service responsive?

Our findings

Although most people we spoke with were complimentary about the care staff, a number complained about timekeeping and lack of punctuality. One person said "Communication and timekeeping are the issues with this agency. People are not informed of significant change".

One relative said "(The care staff) are nice people, sometimes a little slow but they do provide good care so I have nothing to worry about other than they are often late".

Three people told us they had had to raise concerns with the agency about timekeeping. Timing of visits can be more critical when the care provided includes medicines or food and drink. One relative told us "Poor timekeeping interferes with feeding and is unsettling" but said of care staff "They are nice people and provide good care but the office don't seem able to sort out timekeeping". Another comment we received was that "When care staff are late it affects the meal time for (my relative). I do not know whether to make a meal or not".

We looked at the records for one person who was prescribed medicine which the care plan stated was to be taken with a four hour gap in between each dose. We cross-checked the times recorded in the log with this requirement. In the sample of a week that we looked the times at which most visits had been recorded as being made could not have always allowed this gap. This would have meant that the medicine was not being administered as prescribed and in a way that would promote its effectiveness.

One person expressed great frustration at what they saw as a lack of punctuality. They said "Some days I need the care staff to come at the right time. I know sometimes they are held up at the call before me but they should be able to cater for it. It's as if some people don't care". This person told us that they were dependent upon the care staff to help them with toileting but it was impossible to judge how to manage this because they could not be sure when they would attend to assist them.

We saw that the care log included times which were recorded by staff as they arrived and left this person's home. We compared nine consecutive days of these logs with the agreed pattern of calls recorded in the care plan. We found that on each day most of the times of calls fell outside the 25-minute allowed by the provider. The first call of the day was often as much as an hour earlier and the last call was often more than an hour later than agreed. However when we brought this to the attention of the registered manager they told us that the agreed pattern of calls had been revised at this person's request and the programme recorded in the log was no longer correct. This inaccurate information had confused the person as to what service they were entitled to expect.

We noted that the provider had told us that they allowed a 25-minute period either way of the agreed time and that the programme of times in the care plan stated "Please note that any times listed are a guide and not a definite time of a visit". However the effect of this 25 minute period before or after meant that a call could take place at any time within a 50 minute window of the agreed time and still be considered "on time". The feedback we received from some people who used the service suggested that this window of time during which a visit could take place was too long where something time critical such as toileting or meal preparation needed to be completed. We noticed later in our inspection that monitoring of promptness was set at 30 minutes either way meaning that this window could actually be one hour in duration.

Two other people told us that their care staff were usually on time. Both people had calls four times a day. We checked the expected times of calls against actual times. For one person these times were different with the first two calls being earlier than scheduled. However the person told us that this suited them better as they preferred to stay in bed until the second, longer call. They said care staff were rarely unpunctual and always telephoned if they were going to be late. They told us, "They are really good and show initiative for example I like to stay in bed on Sundays and they hoover and do washing for me".

In common with other providers of this type care plan documentation was kept in the person's home so that care staff could consult it and record significant events in it, with a copy retained in the office. We looked at four care plans in the office and saw that they were detailed. The care plans were person-centred which meant that the provider had made sure that they were written primarily from the person's point of view rather than that of the service.

As a result the care plans were divided into sections headed "My personal information" and "My medication" with subsections addressing question such as "Things you need to know about me" (which included information

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Is the service responsive?

about personal safety and security),"My preferences" (which included any choices around the gender of care workers), "What you need to know to support me in my nutritional needs" and "What you need to know to support me in medication".

The provider had also included a one person profile which would help care staff to get to know the person, what people appreciate about them, what is important to them and how they would like to be supported. The simple way that a one-page profile presents this information means that it can be understood and acted upon quickly. Photographs of the person could be included but the registered manager assured us that people could decline to have their photograph taken if they wished.

We reviewed the office care plans for two people. These were detailed and easy to understand. They included a brief history about each person, their personal preferences and people who were important to them as well as contact details, including their GP. Risk assessments included the risk of falls, standing and walking, pain and environment. Where a personal risk was present, details of control measures and any further action or advice were recorded. However we noticed that in respect of environmental risks such as fire there tended to be a standardised wording which did not take account of the individual circumstances of people who used the service (e.g. their mobility and thus ability to evacuate their premises) or the specific risks pertaining to their specific environment (e.g. type of fuel in use, presence of fire or smoke alarms).

Care plans listed any medical conditions each person had and any allergies. It was clear what their assessed care needs where, such as washing and dressing, meal preparation and administration of medicines. Each call time had details of the care and support to be provided at that time and was phrased in a person centred way. For example, the morning call plan started with "What a good morning looks like to me". It then detailed the person's individual routine and support needed.

One of the people we spoke with told us that they had spoken to the manager about a particular member of care staff with whom they had some personal issues and that they did not now care for them anymore. This person was at pains to point out that there had been nothing wrong with the quality of care that that member of care staff had provided.

Care was reviewed by telephone after six weeks. One person had requested a longer morning call but the service had been unable to accommodate it. However, the manager was aware of this and told us they were working towards being able to manage a longer morning call. The person was happy with this when we met them and discussed it.

We recommend that if the registered provider is unable to maintain its stated leeway for the time of calls that it identifies the differences in time criticality of calls on an individual basis so that priority can be given to those where promptness is most important (such as for medicines, nutrition).

We recommend that the registered provider finds more ways in which people who use the service can be reliably informed if their visit is likely to fall outside the agreed time.

We recommend that the registered provider reviews the risk assessments for people who use the service so as to ensure that they adequately reflect people's individual and environmental circumstances.

Requires improvement

Is the service well-led?

Our findings

There had been a registered manager in place at SOS Homecare Halton Service since its first registration with the Care Quality Commission but this had recently changed and the current registered manager had only been in post for a matter of weeks.

Both the registered manager, operations director and care coordinator, all of whom worked for the provider in the office, told us that they undertook some of the care calls themselves from time to time. The registered manager said they did this at least once a month and had visited all of the people who used the service on one occasion or another. We saw the registered manager had returned from undertaking one such call during our inspection. This practice helped her to understand if the needs of people were being met by the service and to review care plans and records maintained at people's homes. The registered manager and office staff demonstrated that they knew the people using the service well by the way they were able to answer detailed questions we asked about people we had visited or telephoned during the inspection.

We saw that the registered provider had put in place a number of audit and monitoring tools in order to check on the quality of service being provided to people. One report analysed the pattern of expected against actual visits using data drawn from the "Careplanner" software system used by the staff via the "app" on their smartphones.

We looked at the last five of these monthly reports, These provided very detailed information and analysis on the duration and promptness of calls. In two of these months late calls (within the registered provider's definition of late as being 30 minutes or more after the agreed time) accounted for 5% and 7% of all calls. For the other months they accounted for 1% or less of all calls. The main reason given for late calls was staff being delayed at a previous visit and road works or other traffic problems as staff moved between people who used the service. We were told that the "Careplanner" system alerted the office if staff were running more than 15 minutes late and the registered manager demonstrated how this worked. She told us that they would always seek to let a person know that they their care staff were delayed if they were alerted to this although it was clear from talking to some people who used the service that for a variety of reasons this did not always happen.

The analysis also looked at the length of time that staff spent on each call and compared this with what had been programmed. This is important because people who use services are given specific durations for their calls for which they are usually charged and can become concerned if the visits are shorter even though the staff may have completed all the required tasks. The analysis showed that the registered provider monitored this in some detail.

Over the period we looked at we saw that full call durations were not adhered to in around 30% of visits. The registered manager had provided a detailed analysis of why this was the case citing such reasons as refusal of care by the person using the service, or a request that the staff leave the house as soon as care was completed. Where this analysis had revealed specific issues relating to the care of people (for example continued refusal to accept personal care) appropriate referrals were recorded as having been made to the local authority. There were also examples of occasions where circumstances on the day had required a member of staff to stay longer than the planned duration of the call. Again where these indicated a change in the needs of people who used the service it was stated that appropriate referrals had been made.

Each month's report outlined the registered manager's proposals for addressing the issue of call duration which included random checking with relatives or people who used the service to verify the reasons for the variation. We saw that staff were continually reminded of the importance for meeting the full duration of the call as scheduled. There was no evidence however that practice had yet changed in this respect. The data collected gave the registered manager some opportunity to influence practice in this area although she had not been in post sufficiently long for this to be demonstrated.

The registered provider also monitored the performance of the agency with an audit completed by a member of staff external to the SOS Homecare Halton Service. These audits were undertaken two monthly and included an examination of records, observation of arrangements in the office, audits of staff and care files and some face to face meetings with people who used the service so as to elicit their views.

The responses by people who used the service reflected a trend of increased satisfaction rising from 87% to 91%. Similar scores were attached to other areas of the audit so that progress could be measured over time. Although these

Requires improvement

Is the service well-led?

reflected an overall trend of improvement we saw that feedback had been provided which included concerns about the administration of medicines such as identified earlier in the report. This meant that the audit process had not succeeded as yet, in delivering the required change in practice in this area. This feedback would help the new registered manager to prioritise areas of practice within the agency which required her attention.

We saw that arrangements were in place for spot checks to be carried out during staff visits to people who used the service. These assessed areas such as staff demeanour, completion of administrative tasks as well as an assessment of the way in which staff interacted with people. Areas included how respect was shown to people, whether people were treated with dignity and offered choice and the opportunity to participate in their care. There was space for people who used the service to comment on the staff member at the bottom of the form although we did not see one which was completed in this respect. Any training needs identified as a result of the spot check were noted.

We also saw that management checks had been made on records which had identified issues which required correction. In one instance saw a check on records which included a check on the deficiencies we have noted elsewhere in this report but which did not comment on or highlight them. These checks appeared to focus on whether the correct entries had been made in the right place on the form rather than whether they accurately recorded care practice.

The registered manager used various means to keep performance at the forefront of staff awareness. In the office a whiteboard displayed recent statistics about staff performance including complaints. A “Carer of the Month” award had been made and publicised both on this noticeboard as well as at a staff meeting. We saw the minutes of meetings at which staff had been reminded of the need for them to raise any concerns that they had, to report to the office if they were likely to be late for a call and special arrangements through which staff could summon assistance if they were in difficulties.

We saw records of staff supervision and development records. These gave staff the opportunity to discuss any difficulties they were having. One member of staff told us that when they had felt they lacked some confidence in medicines’ administration that they had shared this with the management and been provided with additional training.

We were provided with a business continuity policy for use in emergencies. This was a generic policy for use by all the services provided by SOS Homecare Limited.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 The registered provider did not arrange for the proper and safe management of medicines. The registered provider did not provide care and treatment for people who used the service in a way that mitigated identified risks to them.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The registered provider did not maintain an accurate, complete and contemporaneous record in respect of each service user, including a record of the care and treatment provided to them.