Shipston Care Limited

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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

Shipston Care Limited is a domiciliary care agency which provides personal care support to people in their own homes. At the time of our visit the agency supported 29 people with personal care. It also provided a live-in service for one person.

We visited the offices of Shipston Care Limited on 28 July and 10 August 2016. We told the care manager before the visit we were coming so they could arrange to be available to talk with us about the service.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager, who was also the provider of the service, was unavailable at our first visit on 28 July 2016 as they were on annual leave. We therefore returned on 10 August 2016 so they had an opportunity to answer some of our questions about the service and their future plans.

People told us they felt safe with care staff. Care staff understood how to protect people from abuse and about risks to people's safety. They told us they reported any concerns they had to the registered manager or staff based in the office so they could be acted upon.

There were enough care staff to deliver the care and support people required. Care staff generally arrived at the times they were expected and stayed long enough to complete all the tasks required of them. People told us care staff were thoughtful, caring and treated them with kindness. The length of calls meant care staff did not have to rush and had time to deliver care at a pace that suited people. People told us care staff were polite and respectful of them and their homes and encouraged them to do as much for themselves as possible but provided support when necessary. Care staff worked within the principles of the Mental Capacity Act 2005, gave people choices and respected their decisions.

People told us their support needs had been discussed and agreed with them when the service started. They told us they were given a copy of their care plan and the service they received met their needs, choices and preferences. People told us they generally received care from care staff who knew them, although some people told us there had been some changes recently. Each week all the care staff attended a team meeting during which they discussed the needs of the people who used the service to ensure they had the information they needed to respond to changes to, and risks in people's health and wellbeing.

Staff felt they received an induction and training that supported them in meeting people's needs effectively and told us they supported by the managers and office staff. Care staff enjoyed working for the service and were given opportunities to discuss the service at regular team meetings.

People knew who the managers of the service were and were able to share their views and opinions about

the service they received. People told us they would not hesitate to complain if they had cause to do so.

Overall people were pleased with the service they received. However, improvements were needed to some processes, systems and record keeping to ensure people continued to receive a safe, effective and responsive service and to demonstrate the quality of care provided.

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 felt safe using the service and that care staff treated them extremely well. Staff understood their responsibility to keep people safe and manage risks to their health and wellbeing. There were sufficient staff to cover all the scheduled calls and meet people's care needs. Care staff generally arrived when expected and stayed long enough to do everything that was required.

Is the service effective?

Good

The service was effective.

Staff felt they received an induction and training that supported them in meeting people's needs effectively. Care staff worked within the principles of the Mental Capacity Act 2004. They understood the importance of offering people choices and gaining people's consent before care was provided. People were supported to eat and drink enough to maintain their health and wellbeing. Most people managed their own health care appointments, but staff helped them with this if a need arose.

Is the service caring?

Good

The service was caring.

People were supported by care staff who were thoughtful and caring and who treated them with kindness. Care staff did not have to rush and had time to spend with people as they were allocated sufficient time to do everything that was required. Care staff were polite and respectful of people, their home and their family life. Where possible, care staff encouraged and supported people to maintain their independence.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and people received a service that was based on their personal preferences. Staff understood

people's individual needs and were kept up to date about changes in people's care at weekly meetings. People knew how to make a complaint and told us they would be confident to do so.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People were happy with the support they received and were provided with opportunities to comment on the quality of the service. People knew who the managers were and told us they would contact them if they had concerns about the quality of the service they received. Care staff enjoyed working for the service and shared the provider's commitment to providing a high quality service. However, improvements were needed to some processes, systems and record keeping to ensure people always received a safe, effective and responsive service and to demonstrate the quality of care provided.

Shipston Care Limited

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.

The inspection took place on 28 July 2016 and 10 August 2016. The first day of our inspection was announced. We told the care manager prior to the inspection that we would be coming, so they and the staff were available to speak with us during our visit. The inspection was conducted by two inspectors on the first day and one inspector on the second day.

We reviewed information received about the service, for example the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. 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. The PIR did not reflect some of the issues we identified during our inspection. We also contacted the local authority commissioners to find out their views of the service provided. These are people who contract care and support services paid for by the local authority. They shared information with us about issues within the previous 12 months, but raised no concerns about the service.

During our inspection we contacted people who used the service by telephone and spoke with eight people and one relative. During our inspection we spoke with the registered manager, the care manager for the domiciliary service, four care staff and the administrator.

We reviewed five people's care records to see how their care and support was planned and delivered. We looked at other records related to people's care and how the service operated, including medicine records, staff training records, the provider's quality assurance audits and records of complaints.

Good

Is the service safe?

Our findings

People who used the service told us they felt safe and that care staff treated them extremely well. When asked if they felt safe with staff one person responded, "Yes, absolutely. All the staff I had were great." One person told us they felt safe because, "They have got that manner about them, a professional but friendly manner." Another said, "I know them and they look after me very well." One person told us they felt "very safe" and explained, "As soon as the door is opened they call out and let me know who it is."

Care staff knew how to keep people safe from abuse. They told us about the signs which might indicate a person who used the service was not safe; and knew to report their concerns to their manager. One staff member told us they would be aware of, "Physical signs, how they look and respond and bruising or if someone looks afraid or withdrawn. Without hesitation I would report it. Firstly to the office, but if that wasn't dealt with to my satisfaction, I would report it further." Another said, "I would follow the procedure and see one of the office managers." The registered manager was aware of their responsibilities to share any safeguarding concerns reported to them by staff, with the local authority.

Records showed that not all staff had completed safeguarding training with the provider. However, from speaking with them we were satisfied they knew what to do because they had received training in previous employment and knew to report any concerns about people's wellbeing and safety. The registered manager assured us staff would complete their safeguarding training as a priority.

Staffing levels were determined by the number of people using the service. The care manager told us they ensured there were enough staff to cover all the scheduled calls and meet people's care needs. For example, they told us they had recently refused a care package because they felt they did not have sufficient staff available to safely provide the level of service required. They went on to explain that some staff had recently left the service and this had put pressure on them to ensure all the care calls were covered. The registered manager had successfully recruited new staff and the recruitment drive remained on going. Some permanent staff who had left, had chosen to continue to work as 'bank staff' to cover any absence through sickness or annual leave. The care manager explained this would reduce the pressures on call scheduling and provide consistency of care for people who would continue to receive calls from care staff they were familiar with.

People confirmed that care staff generally arrived around the time expected and stayed long enough to do everything they were required to do. One person told us staff mostly arrived at the expected time but went on to say, "There are times they arrive a little bit late or a bit early". Another said, "Generally (they arrive on time), probably if they have to go to see someone before, they may be a little late sometimes. If they are going to be late, they ring and let me know." People told us staff met their needs.

On our first visit to the office we found care records did not always contain risk assessments for identified risks. A risk assessment is a document used by care staff that highlights a potential risk and details what reasonable measures and steps should be taken to minimise the risk to the person they support. For example, we were told two people were at high risk of falls but there were no risk assessments to guide care

staff on how to manage that risk. Another person was at risk of skin damage, but there was no risk assessment or guidance to care staff on how to minimise the risk. Some people required care staff to support them when mobilising. There were generic risk assessments for moving people who could not move by themselves, but they were not specific to the individual risks presented to each person.

However, care staff we spoke with were confident and consistent when talking about how they managed risks to people's health and told us they knew how to support each person safely. They said if they had any concerns they would report them to the office and the appropriate health care professional. For example, care staff told us if they had any concerns about people's skin, they would refer them to the district nurse and the person's GP. Risks to people's health were also shared and discussed at weekly meetings so care staff were aware when people needed extra support to maintain their safety.

On our second visit we found the registered manager had taken action in respect of risk management. For one person at high risk of falls the registered manager had met with the person and the physiotherapist and completed a falls assessment. A plan to manage the risks had been developed from that assessment. A risk management plan had been developed for a person who needed care staff to use equipment when supporting them to mobilise. The registered manager assured us that risk managements plans would be completed for all identified risks by the end of August 2016. This would ensure that staff had the information needed to manage risk consistently and safely.

We looked at how medicines were managed by the service. Most people we spoke with administered their own medicines or their relatives helped them with this. A few people required staff to prompt them to take their medicines. The support people required was recorded in their care plan. However, when staff described how they managed some people's medicines, it was evident they were administering them rather than just prompting. This meant that it was not always clear if the responsibility for medicines was with the person to take them or staff. One person told us they took their own medicines but said, "They (staff) do say, have you taken them?"

Care staff recorded in people's records that medicines had been taken and signed a medicine administration record (MAR) to confirm this. Not all care staff had completed the MAR for one person whose records we looked at. However, we could be confident the person had taken their medicines because it had been recorded in their daily records. The registered manager told us they would take action to ensure staff understood their responsibilities to complete all medicines records accurately and improve medicines management within the service.

Good

Is the service effective?

Our findings

People told us they felt care staff had the right training, skills and knowledge to support them appropriately and meet their needs effectively. One person told us, "I didn't have one member of staff who wasn't professional and didn't act in my best interests. The quality of care was wonderful, absolutely great." Another said, "I think they are well trained and go out of their way to help people." Another stated, "As far as I know they seem to be able to give me what support I need." A relative said, "I can't say they do things wrong at all."

Care staff told us they received regular training which kept their skills and knowledge up to date. They said when they started working for the service they completed an induction which included working alongside (shadowing) experienced care staff and getting to know the people they would work with. The care manager explained that the induction was flexible to meet individual needs. They said, "We don't set a time limit on it. We get feedback from whoever they have been shadowing. It (working alone) is only when we feel confident and they feel competent." One member of care staff told us they shadowed three different staff members but still felt unprepared for their role. They told us they shared their anxieties with the managers and explained, "It was helpful and positive and they were prepared to assist me where I felt vulnerable." A person we spoke with confirmed, "They (new care staff) go round with one of the others to see what they have to do."

Most of the training care staff received was on-line computer training. Some staff told us they found this a good way of learning but some felt it could be improved. For example, one staff member told us, "Actually it is quite good," whilst another said, "It is okay. It is e-learning so it isn't so in depth or individual as some training I have had. It is a lot more generic." However, staff felt the training they received was sufficient to support them in providing effective care. We asked the care manager how care staff were trained to use moving and handling equipment, such as a hoist. We were told the theory was completed on line, but then the clinical lead provided practical training 'on the job'. We asked what qualifications the clinical lead had to provide this training. We were told they had been trained in moving and handling and had years of experience. However, this was not sufficient to provide certificated training for other care staff. The registered manager told us they would ensure a senior member of staff completed a 'Train the trainer' course so they would have the knowledge to provide the training in line with current good practice.

The registered manager told us training was being further developed to enable staff to achieve the 'Care Certificate'. The Care Certificate sets the standard for the skills and knowledge expected from staff within a care environment.

Care staff told us they received regular support by calling into the office and attending meetings with the managers to discuss their work and personal development. Care staff felt the meetings supported their practice with one staff member explaining, "We discuss where I might be failing and how to go about improving. If I have any problems I can discuss them confidently. Sometimes it gives me the extra knowledge and confidence. It is very important to be able to discuss any issues, which I feel I can do." Another said, "It is good. Staff like supervisions ……..I think it is a positive experience for the staff."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in care services are called the Deprivation of Liberty Safeguards (DoLS).

The registered manager told us there was no one using the service at the time of our inspection that lacked capacity to make decisions about how they lived their daily lives. We were told some people lacked capacity to make certain complex decisions, for example how they managed their finances, but they all had somebody who could support them to make these decisions in their best interest. We found there were no documented mental capacity assessments for these people, so their capacity to make decisions was not clear. The registered manager told us they would review the documentation so it was clear where people required support.

Care staff told us they had not completed training in MCA, but we were satisfied they were working within the principles of the Act. Staff we spoke with understood the importance of offering people choices and one staff member told us "taking away people's rights, decisions or choices" could amount to abusive behaviour. People confirmed that the assistance provided by care staff was very much led by them. One person told us, "They come in and say 'how are you, where do you want your wash, what do you want for your breakfast?' I get a choice. They don't do anything without asking first." Another said, "They do exactly what I want."

Care staff knew they had to gain people's consent before they could provide support and respected people's rights to refuse assistance. One staff member told us, "It is their right to refuse anything we are there to offer. We can't physically make them but we can encourage them and try to explain it is in their best interests."

Most people told us, they, or their relative provided their meals and drinks. However, those people who received assistance with meal preparation were satisfied with how this was provided. One person told us that because of their nutritional needs, staff monitored how much they had to eat and drink. In the minutes of a weekly team meeting we saw a member of staff had raised a concern that they never saw a person eat their meal. This had been shared so staff could be aware and ensure the person ate enough to maintain their health and minimise the risks associated with poor nutrition.

At the time of our inspection visit the weather was very warm. All the people we spoke with told us that care staff always ensured they had enough to drink and were particularly vigilant during the hot weather. One person told us, "They always see I have some fresh water at the side of my chair and remind me I should drink." Others said, "They make sure I have plenty of drink left by my side" and, "They are very good like that. They always give me no end of drink." A relative told us, "I've never come here without a full glass of squash and one of water in front of her all the time."

Most people managed their own health care appointments but staff helped them with this if a need arose. One member of care staff told us, "I go in there and whatever is needed I am happy to undertake." The registered manager told us they had a good relationship with the local GPs and sought the assistance of other health professionals if they needed to.

Good

Is the service caring?

Our findings

People we spoke with told us the care staff who provided them with support were caring and treated them with kindness. One person told us, "They all came in and presented themselves, it was always very friendly and a good start to the day…..We always had a great relationship." Another said, "They are all very kind and very nice."

The registered manager told us that where possible, they introduced people to the staff who would be supporting them, prior to staff working with them. People confirmed this was the case. For example one person said, "They [care staff] were all introduced by [care manager] or if they were following another member of staff around they were introduced." Another said, "They bring him or her along, let me see them and I give an opinion on them."

Care staff told us that they did not have to rush and had time to spend with people as they were allocated sufficient time to do everything that was required. A staff member told us, "They always put in sufficient time." One person confirmed this stating, "Generally we have a fairly good routine. If it is a person (staff member) who has been here before, which it very often is, then they have a good idea of what needs doing. They will ask if I am ready for whatever they are going to do for me. If I ask for a couple more minutes before we start, that is fair enough." The registered manager explained, "When I do a needs assessment and I've seen a client ……. the time agreed is not just the time to do the tasks but what I would call pastoral care time." One person confirmed, "Yes, we do have time to have a little chat about general things."

People told us that care staff were thoughtful and always checked whether there was anything else they needed help with before finishing the call. One person told us, "They always ask me if there is anything else they can do for me before they go." Another told us, "They do everything they are supposed to do and if there is any time left I ask them to do something else."

All the people we spoke with told us that care staff were polite and respectful of them, their home and their family life. They told us staff knew their likes and preferences which helped them to be supported how they wished. When asked if staff treated them with respect one person responded, "Oh they do very much so and I know all their names." Another person told us, "I am very elderly and they are all very respectful." A relative confirmed, "The ladies who come are always respectful to me as well."

People told us that where possible, care staff encouraged and supported them to maintain their independence. One person said, "I do all my own personal care…….If I am not up to standing and cooking, they will do it for me." Another said, "They let you do what you can, but if you can't then they help." A member of staff explained, "It is giving people time….allowing them to do what they can do themselves and where they need assistance, assist them with their agreement."

Staff told us they were conscious of maintaining people's privacy and dignity when helping them with personal care. One person confirmed, "Very often it is a male carer and they are very good at disappearing at the appropriate time to give me a bit of privacy."

Good

Is the service responsive?

Our findings

People told us their support needs had been discussed and agreed with them when the service started. They told us they were given a copy of their care plan and the service they received met their needs, choices and preferences. One person told us, "They did a draft (care plan), they showed it to me and I approved it." Another person told us, "There was (registered manager), my social worker and myself and we did the care plan together." Another said, "The care package was produced and laid down as I wanted it to be."

People said they would not hesitate to raise it if they were not happy with their care plan. One person explained, "I know roughly what it says in the care plan and if I wasn't happy with what I was getting I would ring the office and say so." We asked one person if the provider was responsive if they wanted to make any changes and they responded, "Oh yes, they don't make anything of it." Another person informed us they initially had male care workers, but was not happy with this and asked for female workers instead. They told us, "I never had men again." We saw that people's preferences for male or female care staff were now recorded on their care records.

People told us they generally received care from regular care staff who were familiar with them. The care manager explained that they tried to make sure people were supported by the same team of staff so they received continuity of care. One person told us, "It is pretty consistent, just occasionally I may get someone to fill in for a day, but it is continuity of care with the same person." When asked whether they had consistency of care staff one person replied, "Reasonably yes. There are a few changes if anybody is off sick, but I do know them anyway and they know me." Another responded, "There are a few regulars and a few who come occasionally." However, some people said that recently there had been some changes because "carers come and go".

Care staff had good understanding of people's care and support needs and told us they used information in care plans to inform them how to meet people's needs. One person told us they liked to get dressed in a particular way and they told us the care staff understood that. Another said, "I'm a bit finicky and they are aware of the little things I like."

The registered manager explained there was a process to review care plans regularly to ensure they continued to meet people's needs. They told us, "We strive to review care plans after two weeks of care commencing because a lot settles down in that time and then every three months. If something changes we review straightaway."

Each week all the care staff attended a team meeting during which they shared information and discussed the needs of the people who used the service. This ensured that staff had the information they needed to respond to changes in people's health and wellbeing.

People told us they knew how to make a complaint and would be confident to do so. They knew the names of the registered manager and care manager and told us they would not hesitate to talk with them. Comments included: "I would phone the office and hopefully get to speak to [registered manager]." "I would

ring up straightaway and speak to [care manager] or [registered manager]. He always listens." "I talk to the head, it's [registered manager] but if he is not there, [care manager]."

People had information about the complaints process in their care plans and care staff told us they would support people if they wanted to complain.

The provider's complaints file showed no formal complaints had been received about the service. However, other records indicated that a complaint had been received. The registered manager assured us the complaint had been responded to despite this not being recorded and told us appropriate action had been taken to deal with the issues raised. They assured us they would record the action taken in respect of any future complaints so people could be confident their complaints had been taken seriously and in line with the provider's policies and procedures.

Requires Improvement

Is the service well-led?

Our findings

Overall people were very happy with the quality of care they received. Comments included: "I think it is very good….I have absolutely no complaints at all at the service I receive from them." "I think they are pretty good on the whole, very good indeed." "I have recommended them to other people and they all seem very happy about it." "I think it is excellent, I have had no problems at all."

There was a stable management team in place with the registered manager and the care manager responsible for the day to day running of the service. Everyone we spoke with knew who the managers were and told us they would contact them should they have any issues they needed to discuss or were unhappy about anything. People particularly spoke highly of the care manager who was described as approachable and 'available'. One person told us, "[Care manager] is superb. She is very, very good." Another said, "[Care manager] is very good and if someone (care worker) can't come she will step in and come."

Care staff said they enjoyed working for the service and it was managed well. Staff shared the provider's commitment to providing a high quality service. One member of staff told us, "I think that the overall ethos of the agency is to be the best we can be, superb, but of course we don't always reach the zenith. It is a business but the clients are important. This agency is interested in clients and dedicated to care." Another said, "Since I have been here all my requests have been followed. I have been made to feel welcomed and valued."

Staff felt communication between managers and staff was very good, and support was mostly available when they needed it. However two staff had reservations about the availability of support outside the 'core' working hours. The provider's lone worker policy stated: "All lone workers will be provided with emergency contact details of a responsible person. The lone worker will have the means to contact the member of staff on call or the person responsible for the lone worker at all times when working". However, we were told the hours had recently been reduced so the on-call number was only available between 7.00am and 10.00pm. Some staff told us their last calls did not finish until after 10.00pm which meant they did not have any accessibility for on-call advice should a problem occur after that time. One staff member told us, "There is a good communication line with one of the senior management up to 10.00pm at night." Another said, "During office hours it is great, brilliant communication. Outside of office hours it is not so good." We discussed this with the registered manager who told us they would talk with staff with a view to extending the on-call hours to 10.30pm. They also said they would discuss with staff a system whereby they could be assured that staff completed their final call of the evening safely.

Weekly staff meetings enabled staff to share information about the people they supported and to talk about issues related to the on-going quality of service. One member of care staff described the meetings as 'absolutely brilliant' and said, "It brings you up to date with people you might not have seen for a while and everybody contributes." Another member of care staff said, "Communication is the highest priority and in this job it is mainly lone working so it is nice to bounce off other staff and air any problems with individual clients."

People had care reviews and were asked to complete satisfaction surveys to assess if they were happy with the care and support they received. We did not see any negative comments in the client surveys we sampled.

Whilst people were happy with the quality of care provided we found improvements were required to ensure people continued to receive a service that was consistently safe, effective and responsive. One person told us, "They provide great care but the management side could do with a bit of a tweak."

This included improvements in the completion of some records. For example, risk management plans needed to be completed to ensure identified risks were minimised. Medicine Administration Records (MARs) were not always signed to show medicines had been taken as prescribed. MAR charts stated 'contents of the blister pack' to be administered. Whilst this was acceptable, there was no corresponding record to say what was contained in the blister pack. This information was required to meet the record keeping principle of safe and effective administration of medicines.

Forms had been completed to record some accidents and incidents. However, we identified one person who had sustained a fall when a member of care staff was in their home. This had been reported to the office and a senior member of staff had attended the person's home, but the fall had not been recorded on an accident form. This meant it was not clear about resulting actions to show how risks were being managed. Whilst we were told there was not a large number of such incidents, there was no process in place to review accidents and incidents to identify any emerging trends so appropriate action could be taken if required.

We were told the provider's recruitment process included checks to ensure staff who worked for the service were of a suitable character. This included a Disclosure and Barring Service (DBS) check and references. The DBS assist employers by checking people's backgrounds to prevent unsuitable people form working with people who use services. One manager told us, "We won't take on anyone for this service, we need special carers. We need to be strong with recruitment. It's seeing those staff who have potential." One person we spoke with confirmed, "He (registered manager) is very cautious about who he takes on." However, we found one member of care staff had started working with only a DBS in place and no references. A risk assessment had been completed retrospectively, but not at the time they started working with people.

The registered manager told us they completed spot checks on care staff to assure themselves staff were supporting people effectively and putting their training and knowledge into practice. However, we found only one check had been recorded. The provider's medication policy stated that care staff had their competency assessed before they could assist people with medicines. No competency assessments were recorded and we were aware of one member of staff who had not had their observations completed before they started supporting people. The registered manager explained, "When we have a specific concern, the observations are documented. Where people are behaving correctly and following their training we are not documenting it and we need to do that……I will make sure any new staff, at the point they go out, if they are not being subject to a takeover from [clinical lead], they have an observation of their administration of medicines."

From records and speaking to people we were aware of a few concerns that had been raised by people on an informal basis. We found there was no way to record these concerns to identify if there were any emerging themes so action could be taken. The registered manager said they would implement a procedure for capturing this information, so they could identify when any action was needed.

The registered manager understood their responsibilities to submit statutory notifications from the service. A statutory notification is information about important events which the provider is required to send to us by

law. We identified one event that should have been reported to us and had not been. The registered manager told us this was an oversight and they would ensure all notifications were submitted as required.

The information in the provider's brochure stated they provided a 24 hour on-call service to people. We were told this had recently been changed so the on-call service was only available to people Monday to Friday between 9.00am and 5.00pm. This meant that if a member of care staff did not turn up for a call, people had nobody to contact so they could report it. The registered manager assured us that this was fully explained to people when they first started using the service so they understood the scope of the service that was being provided.

Following our inspection visit we received a detailed action plan from the registered manager. This acknowledged all the improvements we had identified in the processes and systems to enable them to monitor the on-going quality of the service. Some action had already been taken and a timescale had been put in place for the completion of the other improvements. The registered manager committed to providing us with regular updates so we could be assured the improvements had been implemented in accordance with the action plan.