Excel Care (UK) Limited

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Inspection report

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31 May 2016

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Ratings

Overall rating for this service	Inadequate

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Inadequate**

Summary of findings

Overall summary

We undertook this inspection of Excel Care (UK) Limited on 24, 26 and 31 May 2016. The first day of the inspection was unannounced which meant the provider did not know we were coming.

Excel Care (UK) Limited is a care agency which works from an office in Moston. It is a ground floor office and accessible to the public. However we found that on two occasions when we visited, the agency was shut . On the first occasion we rang, the phone was not answered and there was no answer machine facility. On the second visit we rang the number again and this time the provider answered and came to open the office.

The provider of this service was also the 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 overall rating for this service is 'Inadequate' and the service is therefore in 'Special Measures'. Services in special measures will be kept under review and, if we have not taken immediate action to propose to cancel the provider's registration of the service, will be inspecting again within six months.

The expectation is that providers found to have been providing inadequate care should have made significant improvements within this timeframe.

If not enough improvement is made within this timeframe so that there is still a rating of inadequate in any key question or overall, we will take action in line with our enforcement procedures to begin the process of preventing the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration within six months if they do not improve. This service will continue to be kept under review and, if needed, could be escalated to urgent enforcement action. Where necessary, another inspection will be conducted within a further six months, and if there is not enough improvement so there is still a rating of inadequate for any key question or overall, we will take action to prevent the provider from operating this service. This will lead to cancelling their registration or to varying the terms of their registration.

For adult social care services the maximum time for being in special measures will usually be no more than 12 months. If the service has demonstrated improvements when we inspect it and it is no longer rated as inadequate for any of the five key questions it will no longer be in special measures.

People felt safe and supported by the care staff, however when safeguarding concerns had been raised, these had not always been investigated and recorded appropriately.

People were well cared for and there were currently enough staff to support them effectively. The staff were knowledgeable about the needs of the people and knew how to spot signs of abuse. The recruitment

process was not robust as sufficient checks had not been implemented prior to staff commencing work.

Staff sought consent from people before providing care or support. The ability of people to make decisions was not always assessed in line with legal requirements to ensure their liberty was not restricted unlawfully, such as locking a person in their property.

Risk assessments were not always up to date. Care plans were not written with the involvement of the person or their families. People had not been supported to be involved in identifying their support needs. Pre-assessments that included people's likes and preferences had not been completed, but staff knew the people well.

Medicines were not administered safely as staff had not received appropriate training to support this task. Where people were supported to take their medicines, staff were not signing to say this had happened, which could have resulted in medicines being given twice.

Staff had completed training appropriate to their role, however one staff member had completed eleven of the training sessions on the same day. Staff were observed as being kind and caring, and treated people with dignity and respect. They spoke to people with respect. There was an open, trusting relationship between the people and staff, which showed that staff knew people well.

People and their relatives told us they had been asked for feedback about the service they received but there was no record of what actions had been taken to address any identified concerns. There was an open and transparent culture which was promoted amongst the staff team.
Complaints which were received were not recorded formally and there was no accident and incident log completed.

Policies and procedures were out of date and were not being followed. There was no evidence of quality assurance checks or audits being completed apart from on daily records. Even though audits on daily records were being completed, there was no action plan from the findings.

We identified breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have taken at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

This service was not always safe.

Risk assessments were generic and had not always been completed, so potential risks had not been identified or managed.

Staff were administering medicines. They had not received appropriate training and this conflicted with the company's medication policy. Staff were not always recording when medicines had been taken.

Staff recruitment was not robust. Not all required checks had been completed.

Safeguarding incidents were not properly investigated and no actions or learning identified from the outcome.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff did not understand the Mental Capacity Act and how this impacted on the care they provided.

Staff received training to support them in their role. We questioned the validity of the training and the retention of information given that the training was completed online and staff were completing a number of modules in one day.

Staff received regular supervision and felt supported by the provider.

Is the service caring?

Requires Improvement

The service was not always caring.

People were not involved in writing their care and support plans.

Care staff understood how to maintain people's dignity and independence.

People said all care staff were kind and caring in their approach when they supported them.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's preferences were not sought and the service did not update people's care plans to reflect changes in their needs.

Care plans were not reviewed regularly.

Complaints had been received, were not recorded and there was no evidence of actions taken, however the provider could explain what actions they would take.

Is the service well-led?

Inadequate

The service was not always well-led.

There were no formal quality assurance checks being completed, therefore improvements were not identified or implemented.

Staff felt supported by the provider and they felt listened to.

Staff meetings were held and staff felt able to raise concerns.

Excel Care (UK) Ltd

Detailed findings

Background to this inspection

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

This inspection took place on 24, 26 and 31 May 2016 and was unannounced. The inspection team consisted of one inspector.

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 information in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

We spoke with two people, two family members, the provider (who was also the registered manager) and two care staff. We looked at records relating to the service. Including five care records, six staff recruitment files, daily record notes, medication administration records (MAR), audits on the daily records, accidents and incidents, policies and procedures and quality assurance records.

The previous inspection took place in April 2013, where concerns were identified surrounding requirements relating to workers, assessing and monitoring the quality of the service and records. A responsive visit was undertaken in December 2013 and action had been taken to address the concerns.

Inadequate

Is the service safe?

Our findings

People and their relatives told us they felt safe with the care and support they received from Excel Care (UK) Ltd. When asked if they felt safe, one person said, "Yes" another said, "Yes, I've had one or two concerns but [name of person] has been very good at helping me sort it out". Relatives we spoke with confirmed they felt their family members were safe with the care and support they received from Excel Care (UK) Ltd.

Staff told us they knew how to keep people safe by minimising the risks to people. Staff told us they always made sure they locked doors on leaving and placed keys securely in key safes. They also ensured that risks from trip hazards were kept to a minimum by moving things out of people's way.

When we looked at people's care files within the office and in their homes we found there were risk assessments within the files but these had not always been fully completed. This meant the service had not assessed the possible risk to the person or staff member when care and support was being delivered. Where risk assessments had been completed we saw they provided little information about the person. Risk assessments were generic forms with limited information about the risks posed to that person and contained no guidance as to what actions staff should take to minimise any identified risks.This put people at risk from coming to harm.

The failure to ensure appropriate risk assessments had been completed was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We were told by the provider and staff, that people were only prompted to take their medicines and that these were not administered by staff. However, we asked staff to explain how they prompted medicines and they told us they "took the medicine out of the blister packets and give them to the person."

We explained to staff / provider as well that prompting with medication involves reminding a person of the time and asking if they had or were going to take their medicines. The person remains in control of their medicines when prompting occurs.

As care staff were deciding which medicines needed to be taken and were selecting the medicines from blister packs this then constituted medicines were being administered. We asked staff if they had received appropriate training to do this. They told us they had only been trained to prompt. We raised this with the provider who said they did not realise current practice meant staff were administering medicines.

We reviewed the generic risk assessments which had a section for medicines. It stated 'staff must not give people medicines from blister packs and they must not give medicines which family members have dispensed into dosette boxes.' A dosette box is a storage box with separate compartments for days of the week and / or times of day such as morning, afternoon and evening. Dosette boxes can be pre-loaded with medicines and people are then supported in remembering when to take medicines. . We saw a member of staff give a person medicine which had previously been dispensed into a dosette box by a relative. This was contrary to company policy.

When we visited people in their homes we asked one person if staff reminded them to take their medicines; they told us they did. Another person told us, "The carers give me my tablets to take". We checked the Medication Administration Records (MAR) which staff should sign when the person had taken their medicines. We saw there were gaps on these. We spoke to staff about this who explained that they didn't always sign MAR charts as they recorded whether a person had taken medicines in daily record notes. The carer went on to say that they had run out of daily record sheets so were writing on a piece of paper. This was not safe practice as the piece of paper could easily be lost.

A record must be kept of all medicines administered to the person the service is supporting. This needs to be recorded on the correct paperwork in order to provide an audit trail and is vital for other members of staff who visit the person. They could potentially administer medicines incorrectly, which may cause harm to the person. By not recording when medicines had been given there was no audit trail of whether the person had or had not had their medicine that day.

Failure to administer medicines safely was a further breach of Regulation 12 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

At the time of our inspection there were nine care staff providing support for 12 people in their own homes. We looked at six staff recruitment files and found that none contained full employment histories. As one person's residency permit had expired in February 2016, this was raised with the provider who said they were still able to work, but had not checked this with immigration to confirm they were still legally able to continue to work in the UK. We saw the provider had written to and informed another staff member that they were not suitable for the job, but then continued to employ them after the member of staff apologised. Details were not recorded as to what action had been taken. We gathered feedback from the local authority that were also looking at the service and reviewing the recruitment process. We asked the local authority about the checks which had been completed on the suitability of staff employed by Excel Care (UK) Ltd. They told us they were concerned 'that the references were being typed by the provider which meant that you could not prove who had written them'. Checks had been completed with Disclosure and Baring Service (DBS) prior to staff starting working in the service. The DBS is carried out to ensure staff are suitable to work with people who live at the home. The DBS helps employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups.

Previous inspections raised concerns with staff recruitment and a subsequent inspection found they had addressed these concerns. However, from our findings this shows the service are unable to sustain this practice and have failed to complete appropriate checks on staff members to ensure their suitability to work with vulnerable people.

People told us there were enough staff to support their needs. People told us that staff were often late due to traffic issues, however they weren't always contacted to let them know the staff member would be late. People and their relatives told us that staff did not always stay for the required time and that sometimes two carers would be present when they should only be having one.

The failure to complete required checks on staff was a breach of Regulation 19 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff we spoke with had a general understanding around different types of abuse, and what to do if they needed to report their concern. Staff told us, "I'd tell [name of the provider]". Another staff member said, "I'd ring [name of provider]." We found that when safeguarding incidents had occurred, the provider had looked into them but not taken appropriate action. We saw where there had been an allegation made against a

member of staff, the provider had documented their findings from the discussion they had had with the staff member involved. However, we saw no other information had been gathered and no clear action plan put in place to prevent this happening again, other than they were no longer providing care and support for the person involved. We discussed this with the provider who said that the staff member "had not done anything wrong". When asked how they knew this we were told, 'because it was what the member of care staff had told him'.

We saw information had been recorded by the staff member in the person's daily notes and the provider had asked the person to write a statement. We were shown a copy of the statement the staff member had written. This was typed and had not been signed by the staff member giving no indication as to who had written it. Other than obtaining a statement from the staff member, no other information was gathered by the provider, or any further action taken. Not investigating allegations thoroughly and not taking action to prevent incidents from occurring again meant the service was not taking appropriate action to safeguard those people they provided care and support for.

When we were out visiting people we saw an unknown male with one of the carers. This was raised with the provider who said it might have been the person's friend. We highlighted that this unknown male was with the carer and should not have been in the property. The provider said they would look into this further and reiterate to carers they are to visit alone. The provider indicated to us that they knew who the person was and if so; , "Then I know they are ok". We asked if they knew the person, had they completed appropriate checks on the person and if so could we see them. We were not shown any evidence to prove that appropriate checks, such as DBS checks, had been completed. We shared this information with the local authority. This meant people were not being kept safe by the agency.

The failure to safeguard people from abuse was a breach of Regulation 13 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

People told us that when staff visited they wore protective clothing (PPE) when providing personal care. We saw staff visited the office to collect additional boxes of gloves. The provider explained that these were kept in the office to assist with stock control. By keeping these in the office they were able to track the number of gloves used and order new supplies when required. By wearing PPE, this showed us that staff were aware of infection control and took measures to prevent cross-infections occurring.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and their relatives told us they thought the service was effective. They believed care staff had the right skills, training and attitude for the caring role. One person using the service told us, "I think, unless it's a trained nurse. I don't think they could get any better". A relative said, "[I] Don't know if trained, but they understand [name of relative] needs."

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.

The service provided care and support for people who sometimes lacked the capacity to make certain decisions for themselves. We looked at what consideration the service gave to the MCA and whether the service was working within the principles of this.

We found staff had limited understanding in relation to the MCA and how it worked. They understood they should ask people for their consent prior to meeting their care and support needs. We asked staff if they had received any training in relation to the MCA and told us they ' had not received any training in relation to the MCA and did not know what it meant'. When we asked the provider about the MCA, we were told, "Staff have MCA training; we have one person with slight dementia who is able to consent". We were then told that another person was not able to speak with us as they were confused and we needed to speak with their relative. We spoke with one relative who told us that their family member "is unable to make decisions, so staff don't explain what they are going to do". We checked this person's file to see if a mental capacity assessment had been completed in relation to consent to care. We found there was no capacity assessment, nor had it been considered in this person's support plan. No decision had been made about what was in this person's best interest.

People can only be deprived of their liberty so they can receive care and treatment when it is the person's best interest and it has been legally authorised under the MCA. The provider would need to request that the local authority applied to the Court of Protection for authorisation of the Deprivation of Liberty Safeguards if they think the person's liberty must be deprived to keep them safe. The provider did not believe anyone they supported required this at the time of the inspection.

The failure to follow the MCA and DoLS and obtain appropriate consent was a breach of Regulation 11 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

Staff supported people with meeting their nutritional needs, by making their meals as part of their support plan. We asked people we visited if staff asked them what they would like to eat, or whether staff just prepared something for them. One person told us, "Sometimes they ask me what I want to eat and drink, other times they just give me something". Daily records did not always show how much of the meal a person

had eaten and people's support plans did not record if the person required any additional support with meeting their nutritional needs.

This showed that staff did not always give the person choice about what they ate and there was no record as to whether there were any concerns about the person's nutritional input.

We looked at staff training records and found staff had completed online training in areas such as safeguarding and moving and handling. We saw that staff were completing multiple courses in one day. For example, one staff member had completed 11 training sessions on the same day. We raised this with the provider who agreed that this was an exceptionally high number and the person would not have retained the information. The provider said they would speak to the member of staff about this.

Staff confirmed they had attended practical training in areas such as moving and handling. One staff member told us, "We get training every time there is new equipment, such as hoists and stand aids." Staff also said that they were assessed to ensure they were competent to use them.

We asked the provider if any staff member had completed the Care Certificate as part of their induction process. The care certificate provides training for people who are knew to a caring role in order to meet the fundamental standards. They told us no one had, however some staff members were completing further qualifications in health and social care. The provider told us that the length of induction depended on the staff member's previous experience and consisted of essential training in areas such as safeguarding and moving and handling as well as spending time shadowing a more experienced member of care staff.

Supervision sessions were undertaken by the provider every three months in the form of spot checks on their practice. We saw evidence of these happening and the provider had kept a written record of them. Staff also received one formal supervision annually which we were told, was not an appraisal. Staff we spoke with felt this was sufficient and provided them with enough support to carry out their role.

We asked people who used the service and their relatives, whether the agency supported them with accessing other healthcare professionals. They told us they arranged this themselves, but believed if there was a problem, care staff would do this for them.

Requires Improvement

Is the service caring?

Our findings

We spoke with people and their relatives, who told us that all staff were caring and kind. One person said, "They [care staff] are warm, friendly and caring. They always have a bright smile, [this] makes me positive and raises my spirits". A relative told us, " They [staff] are caring and kind."

We looked at people's care and support plans both in the office and those held in people's homes. We found they provided very limited information about the person and their care and support needs. We saw no evidence of people being involved in writing them. When we visited people in their homes, we asked them if they had been involved in writing their care and support plans. One person told us, "Yes, they did involve me in writing the care plans". Another person said, "No, I wasn't involved." A relative told us, "No, the social worker did all that". We asked to look at the care plans being kept in people's own homes. We saw these were poorly managed, providing little information to staff about the care and support needs of the person. The daily record logs contained limited information about the care and support which had been provided and in some instances they had run out of this paperwork and recorded their actions on a 'scrap' piece of paper.

This showed that people had not been involved in the writing of their care and support plan and their views on how they wanted their care to be provided had not been sought.

People we spoke with said staff mostly arrived on time, but there were occasions where they would arrive late. We were told that this was due to traffic. When we visited people in their own homes we observed a carer who was attending to a person needs. We noted from the person's support plan they were due to have care between 12:30 and 1pm. The daily records showed the carer had arrived at 11:50 and they left at 12:20. We spoke to the provider about this who explained that they had spoken to staff about the importance of good time keeping and ensuring that people were contacted if staff members were going to be late.

We asked people if care staff respected their dignity and privacy when providing care and support; people said they did. All of the people we spoke with said care staff announced their arrival. One person told us, "They always ask for my consent before they do anything for me". Staff told us how they maintained each person's dignity by making sure blinds and curtains were closed when providing care and support, and also covering the person with a towel when they provide personal care.

People told us they got on well with the care staff and provider. One person told us, "I get on well with them all. They always have a bright smile. One or two times I've had difficulty understanding them [the care staff] as English is not their first language, but we get through". We asked staff how they supported people to remain as independent as possible. Staff told us, "We encourage them to do it themselves" and "We ask them [people] what they want us to do". We saw how one care worker responded to a person they were supporting during a lunchtime visit. We saw the carer speak clearly to the person and check to see if they wanted a hot drink making before they left. They explained to the person when they were leaving and asked if there was anything else they needed before they left. This showed that care staff acted appropriately when providing the person's care and support.

People using the service had not required the support of an advocate as they had family members who advocated for them.

Requires Improvement

Is the service responsive?

Our findings

People told us they received care which was personal to their needs. However, when we checked people's care files this was not reflected in them. The information recorded was minimal and had been copied from support plans sent by the local authority when they commissioned the care package, onto a generic form. They did not reflect any changes in the persons needs and there was no evidence to suggest that people had had their needs reviewed.

The service did not have any records of complaints, or actions they had taken when complaints had been made. People and their relatives told us that if they needed to complain, they would just ring the provider. One relative told us they had needed to complain when they found carers were not staying for the full visit time. They said, "We told [name of provider] that they [care staff] were leaving 10 minutes early. [Name of provider] agreed to sort it". We spoke to the provider about this and we were told that staff had been spoken to in a team meeting about this. With the introduction of a new electronic system the provider felt that this would be prevented from happening as the system recorded the visit times of staff. At the time of the inspection the provider had purchased the electronic system, but had not yet rolled it out to staff.

We asked the provider how the service listened and learnt from people's experiences, concerns and complaints. The provider told us, "I have learnt a lot. I have made mistakes, I have learnt from mistakes. If a client makes a complaint, I gather them, analysing it. If there are two to three complaints about the same thing, (then I'd) look at it and take action."

The service had not formally recorded the complaint which it had received and there was no record of what actions had been taken. This shows the service did not have an effective complaints procedure in place.

The failure to take appropriate action following a complaint was a breach of Regulation 16 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We looked at one person's care file in their home (with their permission) and asked them about the care and support they received. It was clear from what they were telling us and what was recorded in their care file, that the information recorded was out of date. The care file had not been reviewed or updated for some time, as it was showing details of visits which the person no longer received as they were no longer required. This showed that the service was not updating care plans as people's needs changed. We were told by the registered manager that a person they supported had communication difficulties. We saw there was no communication tool to aid staff when supporting this person's needs. Therefore, there was no way of knowing how staff communicated with this person in order to support them to meet their needs. This showed that the service was not responsive to people's needs.

Care files did not show the person's likes, dislikes or preferences. We were assured by people and their relatives that they considered the service to be good and that care staff knew their likes and dislikes, despite it not being documented. Staff we spoke with knew the people they supported well and knew their likes and dislikes.

We saw the service currently had only female care staff. The provider recognised this and reported that if someone requested to have a male care staff member, then they would go out and provide the care. People and their relatives who we spoke with during this inspection, did not raise this as a concern.

Inadequate

Is the service well-led?

Our findings

People and their relatives we spoke with knew who the provider manager was and spoke highly of them. When asked if they felt the service was well-led, one person replied, "Definitely, yes". People told us that if they needed something to be changed or adjustments made to their care and support needs then they just rang up and "[name of provider] would sort it".

We asked the staff what they thought of the provider, they told us, "I feel supported, [name of provider] is very supportive." We also spoke with the local authority about how they felt the service was managed; they raised concerns about how the service was being run. For example, they were concerned that paperwork was not being completed appropriately and safeguarding concerns were not being investigated properly.

Providers are required to notify CQC of certain incidents which occur, so we can monitor the safety of services and take regulatory action where required. We found this service was not transparent in the way it was working. Records were not being kept to monitor the service therefore the service was not able to learn, and take action when incidents arose. Where issues had been raised there was no evidence of any subsequent actions. The provider was not able to evidence any of the concerns raised.

As part of our inspection we asked the provider how the service was audited for safety and quality, and how improvements were identified and implemented. We were told that spot checks were completed on staff to check they were providing care and support appropriately. We saw evidence to show these had been completed and had not identified any concerns. These visits were undertaken by the provider and were unannounced.

We found the service was only completing formal quality audits on the daily records. There was no evidence of any other audits being completed with regards to safeguarding, care plans, risk assessments or medicines. This meant that any issues or errors were not identified and therefore no actions had been taken. For example, audits had not been completed on support plans and risk assessments, which meant where people's needs had changed, these issues had not been identified and action had not been taken.

We asked to see a copy of the service's accident and incident book and also their complaints log we found there were no records being kept of either. The service did not have an effective system in place to log and follow up any incidents; this meant the provider did not have an oversight of all the accidents and incidents which had occurred at the service and therefore, was unable to respond with appropriate actions if necessary.

The failure to monitor and assess the quality of the service was a breach of Regulation 17 of the Health and Social Care Act 2008(Regulated Activities) Regulations 2014.

We asked people who we visited and their relatives, if they were involved in providing feedback to the service. One person told us they had and said, "Yes, I think they listened." Another person said, "No". We asked if they had any concerns with the way in which the service was managed and one person told us,

"Sometimes I have to ring a couple of times before I get through". We found this to be the case when carrying out the inspection, as we had arrived at the offices and found them to be shut on two occasions. This meant that people could not always get hold of staff when they needed to, showing the service was not accessible to people when they needed them to be.

We asked to look at the policies and procedures the service had in place and found them to be all out of date. We spoke to the provider about this who arranged for them to be updated.

Staff meetings were held and were well attended. Staff told us they felt able to raise any concerns they had at these meetings and we saw evidence of the discussions held in team meeting minutes. We saw that the concerns surrounding people's time keeping had been discussed and actions the service would take if it continued. We also saw suggestions were made by staff members as to how their time keeping could be improved. This showed the service listened to its staff members and supported them to achieve their targets.

Staff described the service as having an open culture and they felt able to go to the provider about anything. People and their relatives also felt they could approach the provider and it would get sorted. Comments from people about the service were "They are the best so far" and "I'd hate to lose them".

We spoke to the provider about the vision of the agency and they told us about their plans to introduce a new electronic care system, to streamline the process and ensure it was up to date and reflected people's current level of needs. When asked what the most important aspect of the service was, we were told, "Staffing; it is important to have people who are caring in this business, who want to care. The majority of people who work for me, they want to do care."