Unity Community & Care Services Limited

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Inspection report

Bithrey House
18 King Street
Honiton
Devon
EX14 1AF
Tel: 01404 548448
Website: www.uccs.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?	Good
Is the service responsive?	Requires improvement
Is the service well-led?	Requires improvement

Overall summary

Unity Community and Care Services is a small family run business that provides personal care for people living in their own homes. The service is provided to mostly older people who have needs related to physical frailty or dementia.

This announced inspection took place on the 26, 27 November and on 8 December 2015. The comprehensive inspection was brought forward because of several concerns raised with us about the safety and reliability of the service. We gave the provider 48 hrs notice of the inspection because the location provides a domiciliary care service. This was so we could arrange to visit some people using the service to get their feedback and to ensure the registered manager was available for our visit. 22 people were receiving a service when we visited.

Summary of findings

At three previous inspections we had also identified concerns about the adequacy of quality monitoring. The concerns included the timeliness of visits and some late visits and about accuracy of care records. On 19 June 2014, when we inspected the service, we had concerns about

people's care and welfare, how quality was assessed and monitored and record keeping. Following that inspection, we took enforcement action in relation to people's care and welfare and required the provider made changes by 5 September 2014.

On 24 September 2014 we inspected the service to check that changes had been made in relation to the care and welfare of people. Although some improvements were made, the service had not improved enough. Visit times remained inconsistent for some people which affected their welfare and safety. Assessment, reviews and care plans were inadequate to meet the needs of people safely and appropriately and to ensure changes were promptly recognised and acted upon. This meant people remained at risk of receiving care that was inappropriate or unsafe.

On the 2 and 3 February 2015 we inspected the service again to follow up whether improvements had been made. At that visit some improvements had been made but we found breaches of regulations relating to consent, staff training, notifications and good governance. We continued to be concerned about the assessment and monitoring of quality. Whilst some systems had been put in place to monitor and check the service, these were not well enough developed to assure and control quality in all aspects of the service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The provider had a number of quality monitoring systems in place such as a rota planning system, a tracking system to check time and duration of visits and several informal communication and audit systems. At this inspection, although some aspects of the services had improved, some risks remained. This showed there were inconsistencies in people's experiences of the quality of service. This meant the provider's quality monitoring systems were ineffective because they had had failed to make adequate improvements to people's care.

We followed up concerns which had been raised with us about the unreliability of the service due to late or missed visits. Although we found no missed visits, some people reported missed visits but not recently. People also gave us mixed feedback about the timeliness of visits and a number of people did not consistently receive their weekly rotas. One relative said, "Now and again, I get one (a rota) but I haven't had one for a couple of months now." This meant people did not always know what time their visit was planned for, or which staff were visiting them.

Some aspects of people's care records had improved but we also identified issues about the accuracy of some of the care records we looked at. An initial assessment of people's care needs and any risks was undertaken with them before the service commenced and care plans were developed and agreed in response, with the exception of two people. However, not all care records were reviewed and updated in a timely way when people's health needs changed, although staff were aware of any changes.

Most people and relatives described positive caring relationships with the staff that supported them. One said, "I've no complaints about the carers, they are very good." Other comments included, "Good staff", and "They are all very nice, it's nice to have a little chat with them." Where people had raised concerns about staff attitudes the management team, they had been dealt with.

People received personalised care that was responsive to their needs. Staff knew people well, and spoke knowledgeably about their care needs and preferences. People were relaxed and comfortable with staff that supported them. Staff were discreet when supporting people with personal care, respected people's choices and acted in accordance with each person's wishes.

People's rights were not protected because staff still did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005. Where people appeared to lack capacity, staff had not undertaken any mental capacity assessments. This meant there was a lack of clarity about some people's capacity to consent for their care.

Summary of findings

People were aware of the complaints process and complaints were investigated and responded to, with actions taken to make improvements. There was a culture of openness and a willingness to explore gaps within the team and to identify ways to improve these. However, people, relatives, staff and health and social care professionals we spoke with expressed more confidence in the leadership of one member of the management team than in others. We concluded the quality monitoring systems in place were not sufficiently robust because they could not be relied on to identify areas which needed further improvement.

We followed up two safeguarding concerns raised with us and were satisfied they had been appropriately reported to the local authority safeguarding team and were investigated, with improvements made, where needed.

Staffing levels at the service were adequate for the number of people the agency cared for and further recruitment was underway. People received their medicines on time and in a safe way.

Staff received regular training and ongoing support through supervision and staff appraisals. They worked closely with local healthcare professionals such as GP's, community nurses, local therapists and social workers. Health professionals said staff sought advice appropriately about people's health needs and followed that advice. People who needed help with nutrition and hydration were supported to improve their health through encouragement and prompting to eat and drink.

We found two breaches of regulations at this inspection. You can see what action we told the provider to take at the back of the full version of the report.

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?

Requires improvement

Some aspects of the service were not safe.

Some people were unhappy with the timeliness of their visits and did not consistently receive rotas to advise them who was visiting.

People were protected because staff understood signs of abuse; any concerns raised were investigated and reported to the local authority safeguarding team for further action.

People's individual risks were assessed and actions were identified for staff to reduce them as much as possible.

Accidents and incidents were reported and measures taken to reduce the risks of recurrence.

People received their medicines in a safe way.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Staff offered people choices and supported them with their preferences. However, people's legal rights were not protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005.

Staff received regular training and ongoing support through supervision and appraisals.

Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

People were supported to receive adequate nutrition and hydration.

Is the service caring?

Good

The service was caring.

Staff were kind and compassionate and treated people with dignity and respect.

People were supported by staff they knew well and had developed close relationships with.

People's privacy was protected and staff supported them sensitively with their personal care needs.

People were consulted and involved in decisions about their care and treatment.

Is the service responsive?

Requires improvement

Not all aspects of the service were responsive.

Summary of findings

People's needs were assessed but some people's care records were not up to date about their current care needs, although staff knew about them and how to care for people.

People received individualised care and support that met their needs.

People knew how to raise concerns and complaints, and were provided with information about how to do so. Any concerns raised were investigated and improvements made in response.

Is the service well-led?

Not all aspects of the service were well led.

People were not protected because the quality monitoring systems in place were not fully effective.

People's views were sought but they were not aware of any actions taken in response.

People, relatives and staff reported some improvements at the agency in the last few months.

Requires improvement

Unity Community & Care Services 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 checked 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 announced inspection took place on the 26, 27 November and 8 December 2015. We gave the provider 48 hours' notice of the inspection because the location provides a domiciliary care service. This was so we could arrange to visit some people using the service to get their feedback and to ensure the registered manager was available for our visit.

The inspection team consisted of an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of home care service. In preparation for the inspection we looked at information we had from previous inspections, from notifications sent by the provider and from direct contact with people.

We visited five people and three relatives and spoke with eleven people or their relatives by telephone to get their feedback and looked at six people's care records. We spoke with ten staff which included the registered manager, another director in the company, care and office staff. We looked at five staff files, training and supervision records. We looked at the rota system and an electronic tracker system used for monitoring the time and duration of visits, minutes of meetings and feedback from a survey of people completed in July 2015. We contacted health and social care professionals who worked regularly with the service and received feedback from five of them.

Requires improvement

Is the service safe?

Our findings

People said they felt safe with the staff who visited them. One relative said, “If it wasn't for the care that he gets he would not be able to live independently anymore….without them there he would not be safe.” Some people had agreed that staff could use a key safe to access their home, for their safety and protection.

We followed up concerns which had been raised with us about the unreliability of the service due to timing of visits and reports of missed visits. Five of the 16 people we spoke with said they had previously experienced a missed visit. Some people, once they had spoken to the agency had a care worker sent round immediately. Other clients, who had relatives living with them, had been asked if they could help out because of staff shortages. However, people said this had improved over the last six to eight weeks and we did not find evidence of any recent missed visits. One person said, "The number of missed calls has decreased drastically during the last six weeks. Up till then I was getting at least one or two missed calls each month. However I would phone up the agency and insist they sent me someone which they did do.”

Several people and relatives raised concerns about the timing of visits. They said some visits could be either much earlier or much later than planned. Where people had contacted the agency to discuss this with them, they said the provider had apologised and said that they were working towards addressing this but couldn't promise a solution overnight. Some relatives said they had been asked if they could help out because of staff shortages. One relative said, "I have been rung up and asked if I would mind covering for a carer where they have had staff shortages. Whilst I don't mind in an emergency …it really shouldn't be me they are relying on when they have a problem."

Another relative said, "Lately, the visits have been getting later and later both in the morning and in the evening. I have explained to the agency that it's not good for him to be lying around in bed for too long in case he develops a pressure sore. We have had to rearrange his activities to take place in the afternoon rather than the morning because we cannot guarantee he we will be up and ready in time for a morning appointment.” A relative said, "I don't mind my carer being a little bit late, …. but when I'm still waiting an hour and a half after the time, it can be very frustrating.”

Most people said they were happy with the service they received; they had a small number of care staff that visited them on a regular basis. They said staff stayed for the required visit time and did all that needed doing before they left. One person said, “If I'm not ready to start as soon as my carer walks through the front door she will let me just have a sit down while she carries on with some of the other jobs. It is only when I feel alright that we will do things like washing or dressing me."

Staff reported people had improved continuity of care because they received care by a small number of regular staff they had got to know. Staff said they usually arrived within 15 minutes of the agreed time, and could get their work done in the time allocated for each visit. They said problems with timeliness more often occurred at weekends, if there was staff sickness, traffic delays or when they needed to spend longer with a person. Staff confirmed that where two staff were needed for a visit, they were available, which ensured people were cared for safely. None of the staff we spoke with were aware of any missed visits. We asked about staffing levels, and some staff felt more staff were needed. This was because a member of staff had left the agency and another was leaving but so far, no new staff had been recruited to work at the agency since the last inspection. A bank staff member and other staff confirmed they were willing to work extra hours until replacement staff were recruited.

We asked the registered manager about current staffing. They confirmed the agency employed seven care staff and a director also provided care. Two packages of care had recently ceased so less staff hours were needed. The registered manager said the agency had less people and less complex packages of care than previously. They confirmed they assessed they were adequately staffed to care for the needs of the people they currently supported. They said they did not plan to take on any new packages of care until they had recruited more staff. They were in the process of recruiting replacement staff but had not had any success so far, although said they were being very careful to only recruit the right staff.

Requires improvement

Is the service safe?

The provider confirmed there had been no missed visits over the past two months, although they were aware that some visits were not at the agreed time, which they said was mostly due to staff sickness. We concluded staffing levels were adequate for the service provided.

Since the last inspection, staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. All staff said they could report any concerns to the manager and were confident they would be dealt with. We followed up two concerns raised with us about suspected abuse and found they had been appropriately dealt with. For one person, whose deteriorating mental health was putting them at risk, the provider had appropriately contacted the person's GP, community nurses and worked with their social worker and the local authority safeguarding team. This was to seek urgent assistance and reduce risks for the person, who has since been admitted to a nursing home for assessment. We followed up a second safeguarding concern reported to us about unexplained bruising. The investigation showed this was related to an emergency moving and handling manoeuvre. The local authority safeguarding team who investigated the incident and professionals involved were satisfied with the circumstances and explanations given.

Individual risk assessments were carried out and identified ways to manage and reduce individual risks for people. For example, in relation to risks of malnutrition and dehydration, medicines and skin breakdown. These were reviewed and updated regularly, although it wasn't always clear which information was the most up to date because the records were handwritten,

Environmental risk assessments were completed which highlighted any risks for the person/staff such as any slip, trip or falls risks. One relative told us how a member of staff identified a person was in danger and called the fire brigade who helped their relative to escape from a dangerous situation. Accidents and incidents were reported and reviewed and staff identified ways to further reduce risks as much as possible.

People received their medicines on time and in a safe way. A detailed assessment was undertaken to assess what level of support people needed with their medicines. Staff were trained and assessed to make sure they had the required skills and knowledge. The agency arranged to collect some people's medicines from the pharmacy and deliver them.

Records of medicines administered were well documented. The registered manager said medicine administration records (MAR) charts were monitored and checked each month, so any discrepancies or gaps in documentation were followed up. However this audit system was not documented so could not be verified. Any medicines errors were reported and there was evidence of action taken to improve medicines management and therefore people's safety.

People confirmed staff washed their hands before and after providing care. Staff used personal protective equipment such as aprons and gloves when providing personal care, which reduced the risks of cross infection.

Requires improvement

Is the service effective?

Our findings

Where people lacked capacity, their legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Where people had been formally assessed by other agencies as lacking capacity, there was evidence staff participated in best interest decision making with other health and social care professionals. However, where people appeared to lack capacity to make day to day decisions, staff had not undertaken any first stage mental capacity assessments. This meant there was a lack of clarity about some people's capacity to consent for their care. The registered manager and another member of office staff confirmed they had undertaken additional training about assessing mental capacity. They showed us the assessment tool they planned to use on any new clients, although they had not used it on any existing people. The framework included a section to record how staff could assist people to make decisions for themselves.

For two people, whose care we looked at, their relative had signed written consent on their behalf, although they were not legally authorised to do so. This was because they had power of attorney, but we found this was for making financial decisions, not for decisions about their care and welfare. This meant people's rights were not always upheld because staff did not consistently act in accordance with the requirements of the MCA.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People confirmed staff sought their day to day consent for their care and treatment. For example, comments included, "My carer always asks me what I'm going to be wearing that day" and "I'm very much involved in how and what order we do things in." Staff had completed training on the MCA 2005 and demonstrated a good understanding about getting consent from people. One staff said, "I offer (the person) a wash, if she says no, I explain it is up to you but that her skin might get sore and then she normally accepts care."

An initial assessment was undertaken with the person and any relatives to establish their care needs and any risks before the agency provided any care. This assessment included a detailed assessment of moving and handling, nutrition and hydration and skin care needs. Staff said these were reviewed every six months or more often, if needed.

One person said, "My son and I met with the manager from the agency before they started providing care. We now have a meeting I think about once a year, and we look at the care plan to decide whether any changes need making." A relative said, "My husband's care plan is in his folder. Over the time that we have been with this agency, the care plan has been reviewed a number of times and changed as his situation has changed."

Staff were aware of people's care needs and what support they needed. Staff worked well with local health professionals such as nurses, therapists and GP's. Health and social care professionals confirmed staff contacted them appropriately and followed their advice. A social care professional said staff at the agency had worked closely with them to support a person's changing mental health needs. They confirmed the agency had increased their visits to try and support the person to remain at home and had been involved with the family and professionals in a best interest meeting. A health professional said staff contacted them appropriately about equipment needed for one person, although they were still waiting for the agency to come back to them with some measurements, so they could order it.

Recently, the agency had introduced the use of a 'body map'. This was used to document any redness, bruises or marks on skin reported by staff. This meant staff were aware and could monitor healing and refer any concerns to the community nurses for advice.

People and relatives said staff had the appropriate skills and training to carry out their role. For example, in relation to use of a hoist for moving and handling for one person. One relative said, "My husband has to be assisted out of bed with a standing aid. When (named member of staff) is here he feels really well supported even though there is

Requires improvement

Is the service effective?

only one carer, I think because he knows he is very experienced and will guide him through what is happening. When another carer has to come occasionally, the agency will send two girls because it is far safer for my husband to see two carers standing there to support him particularly when he doesn't know the carers very well."

The provider used two external training providers to provide a staff training programme to ensure staff had the right knowledge and skills. This included medicines management, safeguarding, health and safety, food hygiene and practical moving and handling training. A local health professional had done some staff training on hoisting, which they said was well attended.

Staff files we looked at showed staff received regular training. A training matrix was being developed, so the registered manager could see at a glance what training each member of staff had undertaken and when they were next due for updating. Staff were supported to gain qualifications in care, which some staff were in the process of completing.

Care staff received regular support through supervision which included meetings at the office, individual meetings and 'spot checks' in people's homes. Staff had an annual appraisal during which staff received feedback on their performance and identified any additional training and development needs. This showed the agency supported staff to update their knowledge and skills.

The provider supported some people who were at increased risk of malnutrition or dehydration. A relative told us how much they appreciated knowing staff were coming regularly to visit and were ensuring they had regular meals and drinks. Staff knew how to support their needs in relation to eating and drinking. For example, they described how they made sure each person had a drink within reach before they left. Records were kept of what the person had eaten and drank each day so that the next staff who visited were aware when they needed to prompt the person to eat or drink more at the next visit.

Good

Is the service caring?

Our findings

Most people and relatives described positive caring relationships with the staff that supported them. Comments included, "My carer treats me like a member of her family I couldn't ask for anything better" and "My carer takes the time to ask me how I am when she first arrives." Another person said how much they appreciated when a staff member went to the shop for them when they had run out of something.

People commented that care staff had time to do any additional jobs that needed doing before they left. "My mother's carer is very good at just seeing what other jobs need doing while she is there. I will very often come in to find that the duvet has been changed on mum's bed and the laundry is in the washing machine ready to start. None of these tasks are specifically in the care plan, she is just great at noticing the small things." Two people described one or two staff as less caring. One said, "They just seem to go through the motions before leaving to go to the next client."

A staff member describing the people they cared for said, "They are like family to me, I get on with them so well." When we visited another person, another staff member was chatting with them discussing their Christmas food order and helping them decide what to order.

People and relatives were able to express their views and were consulted and involved in decisions about their care, treatment and support. One relative said, "I liked the fact that a manager came and spoke with us and talked about everything my mother required doing before we started with the agency. It was all written up into a care plan and sent to us. I had a number of changes and additions I wished to have made to it, which was done by the office and it was then sent back out to us so my mother could sign it, and a copy now sits in her file for her carers to look at." Another relative said, "We were very much involved in helping to pull the care plan together. Since it was originally written my father's medical condition has changed, but the manager has since visited us to talk through the changes and the care plan has been altered." Several people had signed their care records to confirm they agreed with them.

People and relatives said staff treated them with dignity and respect. Comments included, "My carer has never talked about anybody else that she looks after during the time that she is with me" and "I have no concerns about confidentiality whatsoever." One relative said, "My husband unfortunately has to stay in bed at the minute. However his carer always make sure that he has clean bedclothes and that his sheets cover him totally before she leaves him each morning."

Staff told us about the way they protected people's privacy, such as by covering a person with a towel when they were helping them to wash and making sure their bedroom curtains were closed when they were getting undressed.

Health professionals told us about one occasion where agency staff did not agree with relatives about the level of care one person needed. They contacted the local authority, as they felt the person needed more support. This showed staff acted as an advocate for the person.

Requires improvement

Is the service responsive?

Our findings

Staff said they thought people's care records had improved, were more detailed and accurately reflected their care needs. However, we found inconsistencies in the accuracy of four of the six people's care records we looked at.

Two people we visited had initial assessment documentation but there were no care plans in their home. This had not been identified, although the service had been caring for them for several months. We followed this up with office staff, who said care plans had been completed but these could not be located at the office. One of those people had rapidly changing mental health needs, which meant staff did not have up to date written information about how to care for them. However, office staff had liaised appropriately with the person's GP and with community nursing staff. They said staff were kept up to date about the person's rapidly changing condition during daily discussions at the office, although these were not documented.

A third person whose care we looked at had previously undergone surgery in September 2015 and was confined to bed for a period of time after their discharge from hospital. This meant their risks and care needs had increased during that period. We found this person's care plan had not been updated to reflect this change in care, although staff described appropriate care for the person in bed during that period. This person has since recovered and was receiving their normal care, which was accurately recorded. In a fourth person's care record, it said they did not receive any support with their medicines. However, the person said staff reminded them to take their medicines, which we confirmed when we looked in another part of their care record. These examples showed not all care records were consistently accurate, complete and up to date.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People received personalised care that was responsive to their needs. One person said, "My carer will always ask if I'm ready to crack on and get dressed. If I'm not, she will make my breakfast first and then I'll get dressed. She doesn't mind changing around how she does things for me." Care plans were individualised and included detailed information about each person, their likes and dislikes, interests and people that mattered to them. Daily records recorded how the person was and the care given at each visit.

People's care records showed what support the person needed with care. For example, that one person needed prompting with washing and bathing and encouragement to eat and drink by leaving snacks and drinks for them. Other records included information about food likes and dislikes and individual details such as what mug a person preferred for drinking their tea.

Some people confirmed reviews of their care had taken place with relatives describing examples of things that had changed as a result of the review. They recalled how they had sat with someone from the office to discuss their care needs and how their care plan had been written as a result of those discussions. One said, "The manager worked with our social worker and my husband and I to produce a care plan that reflected everything that he needs doing. It took a while to get this completed but we were happy with the result and at least we know if a new carer comes in she could have a look and see exactly what it is my husband requires." One relative who lived a long way away said how much they appreciated the support organised for the person when their mental health deteriorated. They said, "Staff were good at getting him to co-operate. I was able to contact the agency and always got a response; (named staff member) was knowledgeable and showed initiative."

The provider had a written complaints policy and procedure. People had information about how to raise concerns or complaints when they commenced the service. One person said, "I do know how to make a complaint and recall the manager giving us a complaint procedure and explaining to us when we started with the agency. This was kept in the folder in their home. People said they wouldn't hesitate to contact the office with any problems.

Two people we spoke with said they had complained to the agency. One person said they had to make an informal complaint about recent missed visits. They said, "I was impressed that the manager did at least talk to me about the issue and explained that they were having a recruitment drive which they hoped would alleviate some of the pressure. To give them their due, the situation has improved recently, and certainly, for the last four or five weeks we have not had a problem." A second person told us about their experiences of raising an attitudinal issue

Requires improvement

Is the service responsive?

with the agency. They explained how a member of the management team visited them on three occasions to discuss their concerns, review their needs and agreed changes to their care plan with them. They said they were satisfied their concerns had been taken seriously and they planned to stay with the agency for now. However, they said, "I would like a letter to confirm what we discussed and agreed."

When we asked to see the complaints log we found this information was kept in three separate notebooks by the members of the management team. This meant it was difficult to see at a glance how many complaints there had been or identify and themes or trends. Also, this system meant some members of management team may not be aware of complaints or repeated themes. We discussed the difficulties with the complaints log system with the management team. Following the inspection, the registered manager contacted us to confirm they had introduced a single complaints log system for the service.

We looked at four complaints. These included a concern raised with us about a missed visit. However, the investigation showed this was not substantiated and the visit had taken place. Others were related to a visit being too late, the attitude of a member of staff and a care issue. We found all complaints we looked at were investigated with actions taken to address concerns and were followed up to check the issues were resolved.

The service also received a number of compliments in relation to the care given and thanking staff for their work. For example, "Thanks for caring for a dear friend" and "Pleased with the care, excellent job." Another relative appreciated that staff rang the hospital to find out what was happening about their relative.

Requires improvement

Is the service well-led?

Our findings

Most people said the quality of the care was good and they were pleased with the care provided by care staff who visited them regularly. However, we found the quality monitoring systems in place did not provide assurances about people's experiences of the service, and didn't always highlight issues that needed addressing. Overall, we concluded the quality monitoring systems were not fully effective.

Some people thought staff at the agency's office needed to be more organised. One said, "If they could crack the organisational side and make sure that visits take place at the times that are agreed then I think it would be as near an excellent run agency as it could get." Another said, "Better organisation about who goes where and does what, would really make a huge difference. I'd also like to see included in the timesheets, the details of when the carers have clocked in and out so that I have some proof that my father who suffers with dementia is not being short changed for his visits." In relation to late visits, one relative said, "It's always me that has to phone the agency to find out what is happening. Sometimes they will tell me that they will get somebody else, but other times I just have to wait for my regular carer to get to me."

Four staff worked at the agency's office, an administrator and three members of the management team. They included the registered manager, her husband, both of whom are directors of the company and a human resources manager, who also undertook people's assessments and reviews of their care. There was a culture of openness and a willingness to explore gaps within the team and to identify ways to improve these. However, people, relatives, staff and health and social care professionals we spoke with consistently expressed more confidence in the leadership of one member of the management team, than in others. We discussed this with the management team; the registered manager described how they had become more involved in the day to day running of the agency. They said each member of the management team had distinct roles and responsibilities and worked closely together day to day.

Staff recalled attending a staff meeting several months ago but said they hadn't met recently. Minutes of a staff meeting were seen for April 2015 showed discussion about actions being taken to make improvements. For example, staff discussed some 'lead roles' whereby staff would undertake additional training and act as a resource for other staff, for example in relation to dementia and end of life care. However, staff were not sure what was happening about these lead roles and there were no other staff meeting minutes. When we followed this up with the registered manager, they said they had organised individual staff training in support of these roles, although this had not yet taken place. They said since then staff met at the office each day, which staff confirmed, although no minutes or notes were recorded.

We received mixed feedback about rotas from six people. Some said they arrived half way through the week, some received them occasionally and others said they had never received a rota but would like one. One person said, "Now and again I get one, I haven't had any for a couple of months." Another said, "Sometimes I get a list, but often it doesn't arrive until Thursday." We explored the rota feedback with the registered manager, who confirmed they completed a rota for people each week and sent them to all except one person, whose family were sent their rota. The rotas were sent by post, and others were hand delivered by staff. We concluded from people's feedback, these methods could not be relied on for getting rotas to people on time.

The provider had an electronic tracker system for monitoring the timing and duration of visits, whereby care staff logged in at the beginning and end of each visit. This meant the agency could identify late or missed visits within 15 mins of the planned visit and used this information for billing purposes. We sampled the data for two people's visits which showed detailed information was generated about the timing and duration of visits. We found some unexplained gaps. For example, one person was supposed to have a 45 minute visit at nine o'clock each morning. Six of the visits were around the agreed time but one was 25 minutes early. The length of the morning visits recorded varied from 20 minutes to 33 minutes maximum. We also found that not all planned visits were captured by the system, although the person had not reported any missed visits. A second person had four visits a day, with two staff visiting morning and evening. Similarly, we found some visits were shorter and we could not confirm that two staff visited each time they were supposed to.

We spoke with a member of the management team who said they monitored the rota regularly each day, they

confirmed there had been no recent missed visits. When we asked about the short length of time of some visits, they said these were related to a second care worker attending for a short period to help with moving and handling or to occasions where a person who did not wish staff to stay for the full visit time. However, these explanations did not adequately explain some of gap in entries and there was no record that any checks had been made to verify this. They also said in some geographical areas, the information was not available immediately because of poor signal coverage, but was available by the end of each day. We concluded the system was not being used effectively to provide adequate assurance about the timing and duration of people's visits or to identify improvements needed.

The registered manager and another member of office staff said they checked the care records, when they were returned to the office each month. They described how they read through them and checks for any errors or gaps in documentation, although these checks were not documented. However, the care record audits described had not identified that two people had no care plans nor highlighted the inaccuracies we found in two other care records we looked at.

People and staff reported improvements in contacting the agency at weekends and out of hours. Three members of the management team provided out of hours cover on a rota basis via a mobile phone, which all calls were diverted to. However, we identified some concerns about this system when we followed up the investigation of a safeguarding concern. This was because each of the on call staff had their own notebook where they logged any calls or concerns. The investigation showed relevant information had not been effectively communicated and shared in a timely way between members the management team.

We asked people about whether they had been asked for their feedback about the agency. A few recalled filling in questionnaires but had not received any feedback about any changes or improvements being made as a result. We followed this up and found a survey was completed in July 2015. 19 of 25 surveys sent out were returned and showed people reported improvements made at the service. Some feedback was received about difficulties contacting the office but said staff were helpful, kind and caring. In response, the out of hours on call mobile was arranged. However, other comments included the timeliness of visits, a theme which was ongoing. Also, the provider was unaware of the feedback we received about the number of people who were not receiving their weekly rotas on time. This meant the provider's feedback system was not fully effective.

This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff reported improvements in the agency, they said communication and continuity of care was a lot better and out of hours, they could get a response to calls for advice or to raise concerns. Staff felt able to raise concerns and call and ring in for advice and support. Care staff visited the office each day and reported on any changes and said communication amongst the smaller care team was good. They identified one member of staff in particular, who they approached when any care or health advice about people was needed. One staff said, "She is always there, reliable, writes everything down and gets onto it."

Where concerns about the attitudes, values and behaviour of individual staff were identified, the registered manager said these were followed up with additional supervision, training and monitoring. Where problems with performance persisted, we found these had been dealt with through the agency's formal capability and disciplinary procedures and some staff had left.

Where issues were raised by people, staff or relatives, a log sheet was completed to show what action had been taken in response. We sampled a number of log sheets and saw examples of contact with staff from other agencies, and relatives about the care of people and the actions taken in response. This including increasing the length and timing of visits, contacting professionals for advice in response to people's changing health needs and to obtain equipment for them.

The agency had contingency plans in place to cover staff sickness and manage any adverse weather conditions. People's care needs and risks was assessed using a red, amber, green system so they could ensure the most vulnerable people prioritised for a visit, in the event of any of the emergencies.

The provider had a range of commercially produced policies, procedures and care assessment and records. These which were regularly reviewed and updated to reflect changes in practice, legislation and regulatory

Requires improvement

Is the service well-led?

changes. People's records, staff records and other confidential records about the service were securely stored in filing cabinets at the agency's office, which were locked each evening.

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 11 HSCA 2008 (Regulated Activities) Regulations 2010 Safeguarding people who use services from abuse Arrangements were not in place to ensure people's mental capacity was formally assessed in accordance with the Mental Capacity Act (MCA) 2005 and ensure that staff were acting in accordance with people's consent in relation to the care provided for them. This is a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The system for assessing and monitoring the quality of care people received was not fully effective. This was because it did not identify important areas affecting the delivery of the service such as accuracy of care records, concerns about timing of visits and receipt of rotas. This is a breach of regulation 17 (1) 17 (2) (a) (c) (e) and (f)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.