Unity In Care Limited

Unity in Care ltd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Requires Improvement
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

Unity in Care Limited domiciliary care agency provides care and support to people in their own homes on a short and long term basis. At the time of our inspection 48 people were using the service.

There was a registered manager in post at the service. 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.

We carried out an inspection of this service in response to information we had received about people's care visits being late and being missed. We found the service was not always reliable when staff absences or client emergencies occurred that could impact on other people's visits. People were not assured that they would

Summary of findings

receive the care they needed at the time they needed it. Though the provider had plans in place to deal with foreseeable emergencies, these were not sufficiently robust to ensure the needs of people who used the service would continue to be met as needed. Where delays occurred people were not always informed promptly to determine whether they could remain safe until staff arrived.uk

People did not always get the time they required to complete their personal care routine at their own pace. They did not always receive the time they needed between visits. This made people feel rushed. Relatives were concerned people were being deskilled as they were not given the time they needed to do things at their own pace. These concerns had been identified by the registered manager during home visits and she had addressed this with staff in September 2014 but improvement was still required.

We received varying views about the staff, the culture of the service and its leadership. Most people were positive and described staff as respectful, caring, and helpful. However, some people did not always experience kindness and consideration. People and relatives knew how to raise concerns but did not have confidence that their concerns would be addressed to their satisfaction. They did not experience the provider to be open to their feedback which at times made them feel they were not listened to and not empowered to influence improvement.

Though the provider strived to improve the outcomes for people effective quality assurance systems were not in place to drive improvement and develop risk strategies. The registered manager used the opportunity when out working with people and staff to assess the quality of the service. Some audits had been completed but systems in place did not effectively identify factors that could impact on the operation of the service, such as the concerns we found.

People were supported by trained staff who received regular supervisions to support them to develop their knowledge and skills. Information in people's care plans were not always sufficient to instruct staff to care for people consistently in line with professional guidelines. Systems for reporting and escalating concerns were not always implemented effectively to ensure action was taken to keep people healthy.

Though people told us they were supported to have enough to eat and drink, we were concerned people did not consistently receive the support they needed to eat at their pace and eat at the times they needed to.

We found although people and their relatives were encouraged to plan their own care, care plans did not record people's involvement. Where people's relatives were involved in decision making records did not evidence if it was their preference or whether they lacked the capacity to make decisions independently. The provider did not have suitable arrangements in place to obtain the consent of people in relation to the care provided. People who lacked the capacity to consent to their care might not have been identified to ensure arrangements were put in place to gain consent in line with the Mental Capacity Act (2005) requirements.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. You can see what action we told the provider to take at the back of the full version of this 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

The service was not always safe.

Robust contingency plans were not in place to ensure people's needs would continue to be met even when staff absences occurred. People were not always informed promptly when their care was running late and the provider did not always check whether people would be safe till their care came.

Staff had received updated safeguarding training and demonstrated they would raise any concerns, to reduce the risk of harm to people.

Recruitment practices were comprehensive to protected people as far as possible from individuals who were known to be unsuitable to deliver care in people's homes.

Is the service effective?

Requires Improvement

The service was not always effective.

Though people told us they were supported to have enough to eat and drink, we were concerned people did not consistently receive the support they needed to remain well nourished.

Staff were trained and supported in their roles and staff who knew people well knew how to care for them in the way they liked.

Care staff had a basic understanding of their responsibilities under the Mental Capacity Act 2005. However, the provider did not have suitable arrangements in place to obtain the consent of people in relation to the care provided Where people's relatives were involved in decision making, records did not evidence if it was their preference or whether they lacked the capacity to make decisions independently.

Is the service caring?

Requires Improvement

The service was not always caring.

People and their relatives gave us varying views about the staff. The majority were positive and described staff as kind, respectful, caring, and helpful. However, some people experienced staff as rushed and impatient.

People were treated with dignity and their rights upheld by staff. Their care was delivered in private and people's property and homes were treated with respect.

Some relatives felt more could be done by staff to support people to maintain their skills and independence.

Is the service responsive?

Requires Improvement

The service was not always responsive

Summary of findings

People did not always receive their care at the time they preferred. They did not always get the time needed to complete their personal care routine at their own pace.

People told us they were involved in planning their care. However, some people had difficulty understanding their risks and care arrangements. Records did not show what efforts had been made to ensure people were empowered and included in the planning of their care.

People knew how to raise concerns but felt action was not always taken to address their concerns to their satisfaction.

Is the service well-led?

Requires Improvement

The service was not well led.

People, relatives, staff and professionals gave us mixed feedback about the culture and leadership of the service. They had at times experienced defensiveness from the provider especially when raising concerns about staff performance or pointing out areas that could improve.

People, relatives and staff did not feel the service defined quality from the perspective of the people using it. We found there were times the leadership was reactive rather than proactive. Though the provider strived to improve the outcomes for people effective quality assurance systems were not in place to drive improvement and develop risk strategies.

Staff valued the care experience of the manager and felt she guided them to improve their care practice. However, some staff did not always feel empowered to contribute to the development of strategies to improve the service.

Unity in Care 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 was an announced inspection which meant the provider knew two days before that we would be visiting. This was because the service provides domiciliary care and the registered manager is often out of the office visiting people or delivering care. We wanted to make sure the registered manager, or someone who could act on their behalf would be available to support our inspection. Before the inspection we reviewed the information we held about Unity in care Limited including previous inspection reports and any concerns raised about the service. We had received concerning information about people's care visits being late and care visits being missed. Some of these concerns were being investigated through the local authority's safeguarding process.

We did not request a Provider Information Return (PIR) at the time of our visit as the provider would not have had time to complete one. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We obtained this information during the inspection.

We visited the provider's office on 14 and 16 January 2015 and made telephone calls to people using the service after this date.

The inspection was carried out by an inspector. We spoke with three people who used the service, five relatives and six care staff on the telephone. We spoke with the registered manager and the business administrator. Following our visit we sought feedback from a social worker and a district nurse to obtain their views of the service provided to people.

We reviewed six people's care records and documentation in relation to the management of the service. This included staff supervision, training and recruitment records, quality auditing processes and policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Robust contingency plans were not in place to ensure when foreseeable events, such as staff absences or client emergencies occurred, the needs of people who used the service would continue to be safely met. The provider told us the reliability of the service had been a problem over the past eight months due to staff absences. In addition to emergency sickness and staff planned holidays, five staff members had required several weeks of planned sick absence at short notice. When a staff member went absent at short notice the rest of the staff including the registered manager, would be allocated additional care visits for the day. Although they would be able to deliver people's care they would inevitably be late. One staff member said "The extra call will probably be at the same time as my current calls so I might then have two calls scheduled for 9 am, I need to decide who has the highest need and go there first". Staff would be asked to change their schedules throughout the day to accommodate, for example, client emergencies or staff absences. The registered manager told us missed calls had occurred when staff rotas had been changed at short notice and they had not realised this. People and relatives told us they had not consistently been informed when their care was running later than the agreed 30 minutes. The provider's response to unplanned staff absences was not sufficiently robust to ensure people who needed their care to remain safe would receive it at the time they needed it. Where delays occurred people were not always promptly informed to determine whether they could remain safe until staff arrived to provide their care. For example, whether they had something to drink and eat, had support from a relative or was in need of more urgent assistance and therefore could not wait for staff to attend.

A number of people relied on staff to help them with their day to day living. Missed or late visits for some people increased the risk of them being left in the same position for long periods without pressure on their skin being relieved. Some people were at an increased risk of falls or injury if they tried to undertake tasks themselves which required assistance whilst waiting for staff to arrive. Other people might not have timely access to food or drink. The impact of care not being delivered on time, without the required number of staff or not at all had not been identified as a risk in people's assessments. Risk management plans had not been put in place to reduce harm to people if this was to occur. The registered manager told us she had agreed contingency plans with people. However people, relatives and staff could not describe what these arrangements were and they had not been noted in people's care plans.

Not everyone told us they felt safe. Relatives told us people did not always receive two care staff as required and assisted staff to deliver the care on these occasions. One relative said "I worry that I won't do it right and that they won't get all their care because we just do the best we can". Relatives did not always have the appropriate training to deliver people's care, like hoisting or turning, safely. Most people and their relatives had experienced late or missed care visits and told us they had on occasion completed some of their care by the time their care staff arrived. One person told us they were not sure if their care would be delivered until they saw their care staff at the door. Another person said "They don't keep to the same time so you worry they won't arrive. They provide good care but being late has just become the way they do things"

The provider was actively recruiting for care staff as well as two care co-ordinators to provide care when care staff were absent. Staff newsletters and staff meeting minutes evidenced the manager was working to improve communication with staff in relation to changes in their care schedules. Further improvement was needed.

The above demonstrated the provider did not have procedures in place for dealing with unplanned staff absences which would be likely to affect the provision of the service. The risks arising from such emergencies to people had not been mitigated. Records showed the service had been informed by staff, relatives and people that 168 visits had been late and 39 visits had been missed over the past six months. The registered manager told us they had not always been informed of late and missed visits and the numbers might not reflect the actual occurrence. This was confirmed by relatives that told us they did not always inform the service when their visits ran late. Though the known late and missed visits were a small percentage of the visits provided over the past six months this affected core aspects of some people's care, including getting up in the morning and essential skin pressure care. People's welfare and safety was not ensured when their visits were late or missed. This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Requires Improvement

Is the service safe?

The provider's accident and incident procedure had been effectively implemented when accidents had occurred. Risk management plans were in place to inform staff on how to reduce the risks posed by people's home environment and their individual risks, including the risk of falls. People told us staff undertook their care tasks safely. Staff we spoke with had a good understanding of people's risk management plans. Records showed staff had alerted the office when people had accidents and action had been taken including calling emergency services to keep people safe.

The staff took action to minimise the risks of avoidable harm to people from abuse. Staff understood the importance of keeping people safe, including from abuse and harassment, and they could describe what was meant by abuse. Staff had completed training in recognising and reporting abuse. There were local policies and protocols on reporting abuse. They said they would report any poor practice or abuse they suspected or witnessed, to the office or directly to the registered manager. Some staff said they had raised concerns in the past in relation to missed calls and people refusing care. The registered manager was aware of her responsibility to report allegations or suspicions of abuse to the local authority and undertook safeguarding investigations when instructed by the local authority. Staff we spoke of could describe the action they needed to take following a recent safeguarding investigation.

Staff held the codes to each person's key safe to gain entry to their home when people were unable to open the door. Following a safeguarding incident where a paper record of people's key safe codes was not kept securely, the provider had made changes to the way this information was shared with staff. Staff told us they now received key safe information electronically via their phone which was password protected. Records showed that following this incident the registered manager had informed staff and the relevant people of the risk of their key codes being compromised. Key codes had been changed to protect people from unauthorised entry. Staff told us that they would reassure people who may not remember they were receiving care by calling out to them so that people knew the staff member was from the service.

We found recruitment practices were comprehensive and the relevant checks had been completed before staff worked with people in their homes. These included up to date criminal record checks, fitness to work questionnaires, proof of identity, right to work in the United Kingdom and references from appropriate sources, such as applicants' current or most recent employers. Staff had filled in application forms to demonstrate that they had relevant skills and experience and any gaps in their employment histories were explained. This made sure that people were protected as far as possible from individuals who were known to be unsuitable.

People received their medicines by staff trained in the administration of medicines. Staff told us they had their competency assessed during induction to make sure they were safe to administer medicines. Staff were only authorised to prompt people to take their medicine from a pharmacy monitored dosage system. Staff had completed records to show that they had prompted people to take their medicine. The medicine administration records in the office had been checked by the registered manager for errors. She told us there had been no medicine errors since our last inspection. Staff could describe the provider's processes for reporting and recording any errors and explained the appropriate action they would take to ensure people were safe in the event of an error. Staff also reported any concerns where people took their medicines independently and we found action had been taken to contact relatives to alert them to the risks. Staff told us all people's medicine support was reviewed if they had any concerns about safety and additional support was then provided if required.

Requires Improvement

Is the service effective?

Our findings

Six of the seven people's records we looked at required some level of monitoring at each visit to keep their skin healthy. Care plans instructed staff to check people's skin and report any concerns that might require additional support from the community nurse. Staff told us once they identified skin changes they had to record them and inform the relatives. This was confirmed by relatives we spoke with. There was a system in place to alert the registered manager when people's health deteriorated. Staff told us they informed the registered manager if ''a person's skin looked very bad''. However, the registered manager told us following a recent safeguarding investigation staff had not informed her promptly of concerns relating to a person's skin. The information in people's skin care plans did not make it clear to staff what type of skin observations were of concern and needed to be reported. People's skin concerns might be overlooked because staff, who did not know people well, might not identify when they were becoming unwell.

The registered manager had provided staff with skin care guidance in the December 2014 newsletter to aid their understanding. Staff we spoke with could describe how they would protect people's skin from breaking down and how they would care for people at risk of pressure sores. The district nurse told us although people received the care they needed she found at times staff's understanding relating to the prevention and management of pressure sores was variable. On these occasions she would provide them with the necessary guidance and told us staff were willing to learn, responded well to her direction and implemented her guidance.

People told us they were supported to have enough to eat and drink. Staff assisted some people with meal preparation and assistance to eat and drink. People said they either told staff what they wanted or staff offered them alternatives, which they could choose from. They said, where preparing food and drinks was part of the care and support package, the care staff always made sure they had food and drinks left within their reach. However, some relatives told us due to the inconsistent timing of visits people did not always receive their food when required. For example, some people living with diabetes needed to eat regularly to maintain their blood glucose levels and would need well timed visits to ensure they have their meals at the required time. One relative was concerned staff did not always support their loved one to eat at their pace. Though staff could describe how they supported people to eat some of the key information they gave was not reflected in people's care plans. In the absence of detailed instruction people might not consistently receive support in line with professional guidelines from less experienced staff.

The above demonstrated people were not always given the support, where necessary, for the purpose of enabling them to eat and drink sufficient amounts for their needs at the times they needed. This was a breach of Regulation 14 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People and their relatives felt overall staff had the right skills and knowledge to meet people's needs. One relative said, "They seem confident and expert at what they do". The district nurse told us staff worked with some people with complex health needs that required specialist care and knowledge in the use of equipment. Staff had been provided with specialist training to meet people's specific needs. They had been trained to work with people who used percutaneous endoscopic gastrostomy (PEG) feeding tubes. Feeding via PEG tubes is a method of giving food and drink to people who are unable to eat or drink orally. Staff also received training and guidance to enable them to people with health conditions like diabetes and Parkinson's disease effectively.

People's physical and mental health needs were assessed and their care planned to make sure they received the support they needed. People told us care staff understood their health needs and provided the support they needed. They gave examples of how staff supported them with catheter care, diet and taking their medicine. Comments included ''They support me to contact my GP'' and ''They will notice if I am not well and ask if I need anything''

Care staff spoken with had a basic understanding of their responsibilities under the Mental Capacity Act 2005(MCA) and making decisions that were in people's best interests. People and relatives said care staff sought people's permission before completing any care or support tasks.

The registered manager and care staff told us all the people supported by the service had capacity to agree to their care arrangements. Relatives however, told us they made decisions about people's care as people could not always do this themselves. Care plans held in the office had not

Requires Improvement

Is the service effective?

always been signed to evidence people had agreed to their care arrangements. Daily contact logs indicated that some people's care were discussed and agreed with their relatives. Care plans did not show what role people's relatives played in making decisions about people's care. Some people might have chosen for their relatives to be involved in decision making. Some people might however, not have the mental capacity to make decisions about their care. Three of the seven care plans we looked at noted that people did not always understand their care arrangements and safety strategies. Records indicated the provider had not completed mental capacity assessments to determine if these people could agree to their care arrangements or required a best interest decision to be made in line with the MCA requirements

The provider did not have suitable arrangements in place to obtain the consent of people in relation to the care provided. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

People were supported by trained care staff. New care staff received a comprehensive induction that took account of recognised care sector standards, relevant to their working in the community and their role. Regular ongoing training was provided and staff spoke positively about the training received. The registered manager held a training qualification and training was delivered at the office. Staff confirmed the registered manager routinely worked with them to observe their practice and addressed shortfalls promptly. People were assured when staff's performance fell under an acceptable standard action would be taken to improve their practice.

Staff received support to reflect on their work and to identify the improvements they needed to make to understand people's needs and deliver effective care. Supervision, performance appraisal and peer support arrangements were in place. Staff received regular supervision often in a group to discuss a specific person's needs and care requirements. Staff told us they benefited from the peer support and these meetings ensured they worked consistently when supporting people. The registered manager had reminded staff of the importance of attending supervision and told us she would be taking action where staff continued to miss their supervision sessions.

Requires Improvement

Is the service caring?

Our findings

People and their relatives gave us varying views about the staff. The majority were positive and described staff as respectful, caring, and helpful. We heard of many examples where staff supported people with kindness, tenderness and patience. One person told us "I have a really good relationship with my regular carer. She understands I like consistency and is really good at letting me know if anything is going to change". One relative said "They are always sensitive when supporting my wife and they are really kind to me too".

Other comments received from people and their relatives were not so positive. One relative told us "I'm mainly happy with the carers but sometimes one will rush her and can become impatient". One person said "Because there isn't always enough staff I get carers that do not know me that well. They can get a bit impatient at times if I tell them how they need to do things". Another relative also spoke of care workers being impatient and rushed.

Staff described how they tried to involve people in their care. People's care plans informed staff of the level of support people required and what they could do independently. Staff said they would ask people what they wanted done or if they needed assistance rather than presuming people could not complete a task. One staff member told us "You have to ask people every time when and how they want things done. It gives people control over the basic things in their life". Another staff member described how they completed a person's personal care. They told us they worked through a sequence of routine tasks as it was easier for the person to understand and stay engaged with each step. People we spoke with told us staff gave them the opportunity to be as independent as they wanted to. One person said "They never take over. If I can do it myself they leave me to get on with it".

The support people received from staff to maintain their skills and remain independent were variable. Two relatives told us they felt the approach taken by care staff to enable people's independence had not always been consistent. The registered manager had identified this inconsistency whilst undertaking care visits. They had discussed their observations with staff at the September 2014 team meeting. They stressed staff needed to work with people in a consistent manner so they were supported to "Do as much for themselves for as long as they can".

People with communication needs were supported to make their wishes known. People told us when staff were not rushed they took time to talk with them in a meaningful way. Care staff could describe how they supported people with speech impairments and learning disabilities to express their wishes and be involved. This included communicating through hand gestures, short sentences and giving people time to respond.

Relatives and people told us their privacy and dignity was maintained. Staff received training to ensure they understood how to respect people's privacy, dignity and rights. The registered manager assessed how staff put these values into practice when observing their work and told us she had not identified any concerns. Staff said they also believed people's privacy and dignity were promoted and well maintained. They told us they used people's preferred names, spoke in a friendly and respectful manner and tried to put people at ease.

Staff described how they ensured people had privacy and how their modesty was protected when undertaking personal care tasks. People told us that staff closed curtains and doors before undertaking bathing tasks. Relatives said staff would respect and be conscious of other people in the house, at the time of their visit. Staff knew people's individual dignity needs and adjusted their approach to accommodate these. They gave examples of how they were aware some people become self-conscious when supported with personal care tasks. Staff told us they ensured personal tasks were completed discreetly. People who found intimate care intrusive were reassured and approached with sensitivity.

Requires Improvement

Is the service responsive?

Our findings

People said although the service met their care needs, their care visits did not always take place at the agreed time. The registered manager and staff told us care visits were at times later than the agreed 30 minutes delay due to unplanned staff absences. Relatives felt this impacted on their day as they could not plan other activities until their care visit had been completed. Particularly relatives who worked found the regular late visits disruptive. They told us at times their extended caring responsibilities, whilst waiting for care staff to arrive, impacted on their employment responsibilities.

People who received multiple care visits throughout the day did not always get the time agreed between their visits. One relative told us "If they run late in the morning this means that her toileting routine for the day can be disrupted as the morning visit will be too close to the lunch time one. " The community nurse told us this could be particularly disruptive for people who also receive regular community nurse visits. They told us "We try not to visit at the same time as Unity in Care, but when they are late our visits fall on the same time. People must feel invaded with so many in their house at the same time. I understand they try their best and delays do happen but it does impact on families".

People did not always get the time they required to complete their personal care routine at their own pace. One relative told us "I worry that she will lose her confidence when using the toilet because she says staff appear rushed and want to get things done". Another person told us they felt rushed at times. Care staff agreed at times they were under pressure when running late for visits and this might impact on people feeling rushed. They told us occasionally due to their visit pressures they did not remain for the full duration of the agreed visit time.

People and their relatives told us they were involved in the assessment, planning and regular review of their care. This involvement had not been noted in people's care plans as evidence that people and their relatives had been given the opportunity to say how they would like their needs met. Records did not show when people had difficulty understanding their risks and care, efforts had been made to ensure people were empowered and included in this process

Care plans noted information about people's needs, preferences and risks. People and their relatives told us new care staff usually came for an introductory visit with an experienced staff member. This enabled them to become familiar with people's care routines and preferences. However, care staff told us with the current staffing pressures this had not always been possible. People and relatives spoke of not always having received care from the same care staff members that knew them well and delivered their care the way they wanted. One person told us "I like it when the carers that know me come, it is much nicer". One relative said "It is always easier for her when it is the same carers that know how to support her. She struggles with the lack of consistency". Another person however told us that the agency had accommodated his need for consistency and ensured he always received care from the same staff.

People and their relatives told us they would and had called the office if they were unhappy about any aspect of the service. The registered manager told us since the last inspection in July 2014 the provider had received one formal complaint. A full investigation of the complaint was evident and the provider's response noted what actions were to be taken to minimise further occurrences. The registered manager told us people should contact the office in the first instance if they have any concerns. The provider's complaints policy did not reflect this and the registered manager said she would review and rectify this policy.

Where relatives had raised concerns about the service they did not feel confident that this would result in sustained changes. Some relatives told us their concerns had not been addressed to their satisfaction. The provider's record log showed nine concerns had been raised since July 2015. The registered manager told us they "Will always look into people's concerns". There was some information in people's communication logs noting the action the registered manager took when a concern was raised. However, records did not show whether people had been satisfied with the outcome of investigations. Though the number of complaints and concerns were noted at a monthly management meeting it had not been noted whether the provider's response had brought about sustained improvement. Concerns predominantly related to late care visits. The registered manager described some of the learning resulting from concerns including informing

Requires Improvement

Is the service responsive?

people that their calls were running late. People and relatives told us that that this learning had not been sustained and they had not consistently been informed when visits ran late.

Requires Improvement

Is the service well-led?

Our findings

People, relatives, staff and professionals gave us mixed feedback about the culture of the service. They told us the registered manager and staff worked very hard. They were described as committed to providing a high quality service, valuing people and leading by example through good care practice. Several people, relatives and staff told us they did not always experience positive leadership from the provider. They felt the provider did not always promote an open supportive culture where people and staff were partners in improving the service. One professional said they would find it helpful if the provider informed them of the challenges they faced so that they could work together at finding solutions before issues occurred. Some said they had at times experienced defensiveness from the provider especially when raising concerns about staff performance or pointing out areas that could improve. One relative said "I do not have the time or energy to always worry about whether I have offended, I need to know I can openly express my views without it being seen as a criticism". Another said "I felt the registered manager was under a lot of pressure which made me feel I wasn't listened to.

People and relatives told us they required increased transparency from the provider regarding action taken to address concerns. They felt they had to develop their confidence in the provider's ability to make improvements to the service. One person said "They just seem to be fire fighting and it doesn't get better. It does not give me confidence".

People, relatives and staff had the opportunity to feedback to the provider on the quality of care provided. They told us they did not feel the provider defined quality from the perspective of the people using it. A client/relative satisfaction survey was completed annually. The results from the last survey in July 2014 were positive and people expressed a high level of satisfaction. These results did not reflect what people, relatives and professionals told us. We received comments about the service needing to improve before people could feel they received high quality care. These included the provider ensuring greater consistency of staff, not sending new staff without an introduction, minimising incidences of late visits and assuring all care visits were attended by care staff. The survey questions however, did not prompt people to comment on the punctuality of their visits and the impact it had on them when calls were not on time. Though this survey had been undertaken by the provider to gain people's satisfaction with the service, it had not been effective in identifying the concerns we found as well as the concerns people and relatives had alerted the provider to, as noted in the provider's contact logs.

We found there were times the registered manager's leadership was reactive rather than proactive in identifying shortfalls in service delivery and risks. The registered manager told us she was aware of the challenges the service faced in relation to time keeping. However, comprehensive learning had not taken place from investigations of late and missed visits. The registered manager had investigated the reasons why visits were late or missed. She was addressing staff absences and communication of visit changes. However, she had not routinely investigated or recorded the impact these incidents had on people's safety. This did not ensure lessons could be learnt to minimise the risk to people of repeat events and harm. The service did not operate an effective missed/ late visit policy to ensure staff and managers knew how to identify and respond to these incidents including checking people were safe and reporting missed calls to the relevant local authorities.

The registered manager used the opportunity when out working with people and staff to assess the quality of the service. Robust quality assurance such as infection control, accidents/incidents, care plan records, visit timings and complaints audits were not in place to support the manager to identify shortfalls in systems promptly. Where some checks had been completed, they had not effectively identified factors that could impact on the quality and safety of the service, such as the concerns we found. The current checks did not always help the registered manager to understand how shortfalls were impacting on people and staff. Routine reflection and learning from people's daily feedback to drive improvements across the service was not evident from monthly management meetings.

The above demonstrated the provider did not operate and effective system to enable them to identify, assess and manage risks relating to people's welfare and safety. This is a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The provider kept informed of current good practice guidance by working closely with community specialists like the district nurse and physiotherapists. The service

Requires Improvement

Is the service well-led?

took part in national good practice initiatives to drive improvement including the Dignity in Care and the Social Care Commitment projects. These supported staff to understand dignified care and how to ensure people were involved in their local community. Actions from this learning had not been included in the service plans to ensure staff responsible for completing actions were held accountable by the registered manager.

Staff had confidence in the registered manager's practice knowledge. They told us that feedback from the registered manager was constructive and informed them of the action they needed to take. This was confirmed by the staff meeting minutes and quarterly newsletter that showed how the registered manager kept the service values and behaviour of staff under review. Staff had been made aware of maintaining professional boundaries and treating each other with respect in the September 2014 meeting.

Staff told us they generally enjoyed working for the provider and this was confirmed by the positive results of the provider's '2014 Staff Culture survey'. At the time of the inspection staff felt stretched and did not have confidence that the current staffing pressures would be resolved soon. Staff had mixed views about their ability to influence improvements to the service. Some staff told us their views on the day to day running of the service were actively sought by the provider and they felt confident that their recommendations would be acted on. However, other staff told us they had views on how visit scheduling could be improved but did not feel they always had the opportunity to influence the way visits could be scheduled to improve timeliness.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services The registered provider did not have procedures in place for dealing with emergencies which are reasonably expected to arise, and which would be likely to affect the provision of service, in order to mitigate the risks arising from such emergencies to service users. Regulation 9 (2)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered provider and registered manager did not protect service users against the risks of inappropriate or unsafe care. Systems designed to enable the registered person to regularly assess and monitor the quality of the service, identify, assess and manage risks relating to service users, were not effectively operated. The registered provider and registered manager did not where necessary, make changes to the care provided in order to reflect information relating to the analysis of incidents that resulted in, or had the potential to result in, harm to a service user. Regulation 10(1)(b) 10(2)(c)(I)

Regulated activity	Regulation
Personal care	Regulation 14 HSCA 2008 (Regulated Activities) Regulations 2010 Meeting nutritional needs The registered provider and registered manager did not ensure that service users were protected from the risk of inadequate nutrition and dehydration by means of the provision of support, where necessary, for the purpose of enabling service users to eat and drink sufficient amounts for their needs. Regulation 14 (1) (c)

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment In relation to the care and treatment provided for the service user, the registered provider did not have suitable arrangements in place for obtaining, and acting in accordance with, the consent of service users, or the consent of another person who is able lawfully to consent to care and treatment on that service user's behalf; or establishing, and acting in accordance with, the best interests of the service user. Regulation 18 (1)(a)(b)