Taylor Gordon and Co Limited

Plan Care Welwyn Garden City

Inspection Report

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Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on the 10 April 2014. A breach of legal requirements was found. As a result we undertook a focused inspection on the 18 December 2014 to follow up on whether action had been taken to deal with the breaches.

You can read a summary of our findings from both inspections below.

Comprehensive inspection of 10 April 2014.

Plan Care Welwyn Garden City is a large domiciliary care and supported living agency. It is registered with the Care Quality Commission (CQC) to provide care and support for older people with a range of physical, social and psychological needs. On the day of inspection the agency was providing personal care to 335 people in the community.

The agency had a registered manager. A registered manager is a person who has registered with CQC to manage the service and shares the legal responsibility for meeting the requirements of the law with the provider.

We spoke with three people in a supported living home who all spoke positively about the service. We telephoned 13 people who received personal care from the agency in their own homes. We received mixed feedback from these people. The three people we spoke with in a supported living home, said they were very happy with the staff, who understood their needs and helped them to remain as independent as possible. Nine out of 13 people we spoke with who received care within their own homes said they were unhappy with the level of communication they experienced with the office staff but were satisfied with the staff who provided their personal care.

When we talked with staff, four were unaware of legislation regarding the Mental Capacity Act 2005, even though training had been provided. This meant staff may not recognise when an assessment under the Act was necessary to protect people in their care.

There were not always enough staff available to provide the care and support needs for people in their own homes and we found that people were not always informed if their regular staff could not make the visit to provide their care or if they were going to be late.

Although there were some general risk assessments covering the environment and moving and handling, the welfare and safety of some people who used the agency were at risk because they did not have individualised risk assessments that detailed how the risks could be minimised to protect them and the staff.

Staff had completed training in safeguarding and whistleblowing. They also told us that they undertook the provider's core training to develop their knowledge and skills so that they provided good care for people and could meet their individual care needs.

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.

Focused inspection of 18 December 2014.

After our inspection of 10 April 2014 the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches in the report.

We undertook this announced focused inspection to check that they had followed their plan and to confirm that they were now meeting legal requirements. The provider was implementing a new risk assessment document which had been developed in response to the concerns raised. We looked at five care plans, however these had not been amended in response to the concerns raised at our previous visit and did not provide staff with adequate guidance on how to meet peoples care needs. In response to concerns the provider had made the appropriate changes to ensure that people's views were respected regarding the choice of gender of care staff providing their care. There had been improvements made in relation to communication from staff when they were running late, however, this did not happen all the

Summary of findings

time. The call logs still showed that people were regularly late. The provider had not allowed for travel time between calls which meant that staff continued to be regularly late.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

10 April 2014

People told us there were not enough staff to meet their needs and 11 out of 13 people told us they were not informed if staff were going to be late or if they were coming at all. They told us that the service was particularly unreliable at the weekends. People told us they did not always get the medicines they needed on time.

Four out of the six staff we spoke with did not understand their responsibilities in relation to the Mental Capacity Act 2005 which meant that people's rights in this area may not be respected.

There were no individual risk assessments for people to cover risks from people's behaviour or communication difficulties.

We found that the service had effective systems in place to identify abuse and respond appropriately.

18 December 2014

We found that communication had improved and people were better informed when staff were running late, however this was not consistent. People did not always receive their care at the allocated time

People's care was sometimes delayed which included the administration of medication. There were risk assessments in place but no clear guidance for staff with regard to behaviour and the associated risks.

Are services effective?

10 April 2010

Although staff said they had undertaken training, the majority of the people we spoke with told us that staff were not well trained.

People we spoke with and the care plans we looked at, showed that people had been involved in the assessment of their needs.

Although people's choices had been recorded, some people's care was not always provided in line with their choices, which meant their quality of life could be affected.

Staff told us they were informed if there were any changes in a person's health or requirements, which meant people could be assured staff were aware of their needs.

Summary of findings

18 December 2014

We found care had been provided in line with peoples choices and people were happy with their care. people told us that staff were well trained.

Are services caring?

People we spoke with in one of the supported living properties spoke highly of the staff while people receiving care in their own home gave us mixed feedback. People expressed concerned that they were not notified of changes to staff or if staff were going to be late.

We saw that people were encouraged to remain as independent as possible, and their individual needs were met, when we visited an extra care unit.

Are services responsive to people's needs?

10 April 2014

Staff responded to people's needs but people said they were unable to communicate adequately with the office staff when they needed.

Although the service had a complaints system in place, and provided information on how to complain detailed in the Client Service Guide, only two out of ten people we spoke with were aware of how to make a complaint about the service.

People told us they were not informed which member of staff would be visiting them if their regular staff member was unable or moved to another geographic area.

18 December 201

We found that some improvements had been made and people were happy with the service they received from the office staff. Communication had improved and most people were told about staff changes.

People told us that they knew how to make a complaint and this was clearly detailed in their care plans.

Are services well-led?

Between October 2013 and January 23, 2014 there had only been 10 occasions out of 96000 when staff had not arrived for visits. There was evidence that they had been followed up to see why they had occurred. However there were no systems in place to monitor that there were sufficient numbers of staff to meet the needs of people who wanted regular staff and reasonable times for their visits. Systems to monitor the quality of the service had not identified the concerns we found or led to improvement in these areas.

Summary of findings

Staff were aware of how to raise a concern about any poor practice, but none of them had needed to do so.	

Summary of findings

What people who use the service and those that matter to them say

Comprehensive inspection 10 April 2014

We spoke with three people who used the agency and telephoned 13 others who all received personal care from the agency.

People told us that they were not informed when changes to the staff who provided their care occurred. One person said: "I ring the agency and ask who is coming as there is no rota" and another said, "The agency never tells you if there is a change of care. They [carers] just turn up. I might have seen that particular carer years ago. The carers are suddenly swapped without any pre-warning then we don't have a say in it. We look forward to seeing the people we generally see and then we don't see them."

Eight out of nine people said they felt safe from abuse or harm. This meant most people felt safe in their homes.

One person said: "I need my medication at proper intervals. They [the staff] don't seem to see it as important."

One person we spoke with about the training of staff using the equipment said: "Yes and no. Only a couple of them have had manual handling training – February time they were waiting for their training. We have had no-one coming round to shadow train." Shadowing is when a new member of staff goes with a more experienced member of staff to watch, learn and then assist to help meet people's needs.

One person we spoke with about their involvement in the care plan said: "The agency comes around every now and then, once or twice a year. A chap comes from the office and asks questions about what you think is good or bad. Any changes you would like to see in the care plan. I think the care plan is updated."

We spoke with people and they told us: "Years ago they asked me if I wanted a male or female carer" and another said, "No, was not offered a choice of carers. Sometimes we get one of each, sometimes the same." Another person said: "I told them what time we wanted care, but the times are not even beginning to be adhered to." This meant people did not feel they had been listened to.

Focused inspection 2014

We spoke with forty four people who received personal care from the agency. People confirmed that they had been informed of changes to staff and Twenty five people out of thirty four confirmed they had been informed when staff were running late.

All forty four people said they felt safe. They told us they felt secure in their homes. Every person we asked felt that staff were properly trained and were happy with the care they received.

People told us that their choices around the gender of the staff provided to deliver their care had been respected. Where circumstances had changed at short notice and this was not possible, every effort to communicate this and seek people's consent to the change had been made.

Plan Care Welwyn Garden City

Detailed findings

Background to this inspection

Comprehensive inspection of 10 April 2014

We visited the domiciliary care agency on 10 April 2014. This was an announced inspection, which meant the provider was informed about our visit two days beforehand to ensure managers and staff would be available in the office. Our inspection team was made up of an inspector and an expert by experience, who had experience of domiciliary care services. This person made telephone calls to people who used the service.

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 regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process under Wave 1.

The last scheduled inspection for Plan Care Welwyn Garden City took place on 23 August 2013. The agency was compliant in the five regulations inspected.

Prior to our inspection we reviewed the information we held about the service. This included looking at safeguarding incidents and notifications sent to us by the provider.

During the inspection process we talked with three people living in the supported living service, telephoned 13 people who lived in their own homes, spoke with six staff, the deputy manager and the registered manager. We looked at 11 people's care plans and other supporting documents.

We observed staff when they interacted and provided care to people. We looked at information about people's medication and the way medication was administered. We checked information about the mandatory and specialist training that staff had received.

Focused inspection of 18 December 2014

We undertook an announced focused inspection of Care Plan Welwyn Garden City on the 18 December 2014. The inspection was done to check that improvements to meet legal requirements planned by the provider after our 10 April 2014 inspection had been made. The team only inspected the service against three of the five questions we ask about the service; is the service safe? Is the service responsive? Is the service effective? This is because the service was not meeting some relevant legal requirements in these areas. The inspection was undertaken by two inspectors.

During our inspection we spoke with the manager, deputy manager and six staff and 44 people who used the service. We also reviewed any information we held about the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us by law. We reviewed the provider's action plan and the report from the last inspection. We looked at five care plans and reviewed call logs to assess if calls had been attended on time. We looked at the timesheets for five of the staff. we also looked at the satisfaction surveys completed by people who used the service.

Are services safe?

Our findings

Findings from the comprehensive inspection of 10 April 2014

Although computerised records showed that between October 2013 and January 23, 2014 there had only been 10 occasions, out of approximately 96000 visits, when staff had not arrived to provide the care agreed, ten people we spoke with said there were not enough staff to cover the calls. One person said: "Sometimes the agency is so stressed because they don't have enough people to cover. It is a rush to talk with them because they are busy. If you have had an accident and you need help, you have to wait as they have to find a carer close to you." Another person said: "Last night we phoned the office twice and no-one answered. Carers were an hour late last night and walked in as we phoned again. Carers have been late at least 10 times in the last month (over 20 minutes) and twice we have cancelled them after an hour." Most staff we spoke with said they had been asked to cover too many calls, especially as some of them walked to their visits. Only one person who used the agency was satisfied. They told us: "If I phone them up and ask the agency for anything, they call me back and sort things out, I have no complaint at all."

During the inspection we were told that the office was open between 7am and 10pm seven days a week with on call staff available to cover any visits outside normal working hours. We spoke with six staff who told us that staffing levels were an issue at times, particularly with the on call staff in the office at weekends. One person who used the service told us that they had phoned the on call service at 10.15pm to ask where their carer was but were told: "I don't know, I am out with service users myself and I haven't got my lap top with me". The manager stated that on call staff in the office, who had previously worked in care, were often required to provide care to people when staff went sick at short notice or were running very late. The provider said that if the staff who were on call had to cover visits they diverted the office phone to another member of staff.

People who used the agency did not always receive the care they needed in a timely manner. This meant there had been a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

We looked at eleven care files and saw the only risk assessments in place were for moving and handling and the environment. There were no individualised risk assessments to cover such things as how staff should assist anyone with behaviour that may challenge others or people with communication problems. The manager confirmed this. People who used the agency were therefore not protected or kept safe. This meant there had been a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

The people we spoke with had conflicting views about whether the service managed medication well. Two relatives told us that medication was not administered at the correct time. One said: "X [the person using the agency] is on medication and I have to juggle [a meal] around the carers. All I want is a telephone call." This could impact on people's health and wellbeing because they had not had their medicines at the correct time. Another relative said: "The carers give tablets to X [the person using the service] in the morning and tea time. It doesn't matter if they are later or early. I have never had to do it myself." Staff told us they had received up to date training in medication and that their knowledge was checked and agreed before they could administer medication to people. This was confirmed by records seen. Staff were able to explain how one medication that needed to be administered in a specific way was administered safely to people.

Four members of staff said they had received no training in the Mental Capacity Act 2005 (MCA). They said they did not know how to care for people in their best interests. The manager said she had provided the training to the four staff we spoke with (as well as other staff) very recently. She showed us some of the information staff were given. However, there was no check on whether staff had understood the information given about the MCA. This meant people could be at risk because staff did not understand what they must do to comply with the Mental Capacity Act 2005.

One person we spoke with said they did not feel safe because the agency: "…doesn't take me seriously." We spoke with a health professional and the manager of the agency to ensure the person was not at risk. Eight other people or their relatives told us they felt safe from abuse or harm. One person said: "Yes, we feel fine, no worries about any of the care at all." Another person, when asked if they

Are services safe?

felt confident to phone the office if they were worried about anything to do with their care, said: "Yes, I would feel confident if I knew that something would be done," although another said, "I would feel confident if they could put me through to someone who was the relevant manager."

The manager said that there were appropriate safeguarding policies and procedures in place and training was provided for staff. Staff we spoke with confirmed this. Five staff we spoke with about safeguarding were able to tell us what constituted abuse and the different types they might encounter and what they would do about it. They told us there was information about the policies and procedures available and telephone numbers for the local authority's safeguarding team, the police and other necessary professionals.

Staff said they had the necessary support to protect people when assisting with moving and handling tasks. They told us they worked in pairs when necessary so that people were assisted appropriately. The manager told us that the hoists and slings were checked by staff and if the equipment needed to be serviced; either the staff in the office or the person's relative would arrange that. Staff we spoke with during the inspection confirmed this. There were risk assessments for moving and handling so that people were kept safe when they were moved.

Findings from 18 December 2014 Focused inspection

People we spoke with told us they felt safe and were happy with the quality of care they received. However, people frequently experienced late calls and were not always informed. One person told us, "My morning call turned into an afternoon call. "We looked at the call logs which recorded the times staff arrived and left a person's home. We saw from these that people frequently received care late. The manager told us that a call was considered late after fifteen minutes had elapsed. However call logs demonstrated that people frequently waited longer than fifteen minutes. For example, during one month period a person received seventy one calls, forty one of these calls were over fifteen minutes late with three calls over an hour late. Where calls to people had been identified as needing to be made on time we saw that delays were common place also. Where people required care, they did not always receive this in a timely manner or when required.

Nine out of 44 people we spoke with who used the out of hours service said the service worked well, however one person said, "It was not a good service due to the lack of people managing the phones." Another said, "Worked well, had a good response." We found the majority of people who had used the service had been satisfied.

We saw that people's care plans had risk assessments in place. However the risk assessments we looked at had no clear guidance for staff to follow. In one person's care plan it was noted that the person required two staff to assist with moving and handling but the risk assessments highlighted that there was not enough room for two people to manoeuvre around the person's bed. There was no guidance in place on how staff should manage this. This meant that staff were operating in an environment that could not be managed safely. In another care plan there was a statement to staff that when making tea to ensure that 'thick and easy' is added to this person's drinks. Thick and Easy is used to thicken fluids to help people with swallowing. However there was no guidance in place that stated what quantity of the thickener should be added to this person's drinks. Staff told us that they followed the instructions on the packaging to ensure they used the correct amounts but acknowledged that these were general instructions and not specific to the person they were caring for.

We also found that in one person's care plan it stated that they were allergic to cheese, however this had not been mentioned in their risk assessments. We spoke to staff that provided the care to this person and they were aware of the persons allergy. However if a member of care staff who did not know the person was providing care there is a risk that they would not know about this person's specific dietary needs. Another care plan described a person's behaviour as unpredictable, however there was no guidance in place for staff with regard to how to effectively manage this person's behaviour Staff told us how they managed the person's anxieties and knew what caused the anxieties. This showed that regular staff were aware of the person's needs and were able to provide the appropriate care. However the care plans did not provide enough guidance for staff who did not know the person. Information provided within the care plans was not sufficient for staff to fully understand people's needs.

This was a breach of Regulation 20 of the Health and Social care Act 2008 (Regulated Activities) Regulations 2010

Are services safe?

We looked at a satisfaction survey that had been completed by people throughout November and December 2014. We saw that every person who responded was happy with the care they received. However people also commented that late calls and consistency of the same staff were areas for improvement. One person commented that, "Only problem is that staff do not turn up at the stated time." A second person commented that, "My service is okay when my old faithful's turn up." We checked this person's call logs for the previous month and saw they had received care from twelve different staff. We looked at the timesheets for five of the staff. We saw that when allocating each staff member's workload, consideration had not been given to travel time. Records showed that when one call ended, the following call started. This meant that staff did not have sufficient time to travel to their next appointment and were therefore cutting visits short in order to get to their next appointment within the specified timeframes. For example one person in a one month period had not received over 17 hours of care that had been assessed as required as part of their care package due to staff not staying for their allocated time.

In the recent satisfaction survey one person had commented, "Care workers do not stay as long as they should sometimes." Records showed that this person had not received over 3 hours of the care required. Staff told us that in order to provide care to people they had to cut the call times short. One carer told us, "I catch up by shortening the call, that's the only way I can do it." The manager told us that recent difficulties with recruitment meant that people in rural areas had received calls late; however a review of urban areas showed that people received late calls also. The recent annual satisfaction survey completed at the beginning of the year, had identified late calls as an area for development. However the manager had not developed an action plan to improve this. This meant that there were not enough staff available to ensure the health safety and wellbeing of people using the service as care was often cut short as staff did not have the time to complete their visits. We found that some improvements had been made and people were happy with the service they received from the office staff. Communication had improved and most people were told about staff changes.

People told us that they knew how to make a complaint and this was clearly detailed in their care plans.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2010.

Are services effective?

(for example, treatment is effective)

Our findings

Findings from the comprehensive inspection of 10 April 2014

We asked nine people if they had been asked whether they would prefer a male or female member of staff. The provider said that the policy was not to send male staff to deliver personal care to a lone female. However if there was no alternative the person would be contacted to give them the opportunity to choose. Only two people told us they had been given the choice and one of them said: "I said I wanted female and they sent a male every now and then and I didn't send them away. Gave me tablets, I was ok with that, but I prefer to have a woman, they do know that." We saw that although choices had been recorded within people's care plans, these were not always being met. This meant there had been a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

Eight of the 11 people we spoke with did not think the staff who supported them had received the right training to meet their needs. One person who used the agency said: "Several [care staff] don't know how to use the hoist. A new person goes with supposedly someone who knows the ropes. The other carer doesn't have the experience or training so holds the proceedings up." One person told us: "..my carer is very good; she has had a lot of experience. Some of the younger ones don't know where to start, they don't seem quite so sure, they are probably new". Another said: "Sometimes the younger ones don't know what they are doing. There is no shadow training – they just have to jump in." Information from one person showed that staff did not understand the person's health needs which could exacerbate their condition. The person told us they were not confident to discuss their health needs with staff.

However, the manager told us that all staff had received appropriate training, especially in moving and handling people with a hoist. The manager confirmed that there were only two hoists used by the local NHS and the office had both for use in the training room to be used as part of the 'hands on' training. Staff we spoke with during the inspection confirmed the hoists and other equipment were used. There was evidence in the training records that showed staff had undergone training and staff confirmed they shadowed a more experienced staff member so their competence could be assessed.

The manager said that people who required specific skills from staff who understood dementia, physical disability or learning disability, had appropriately skilled staff provided. Staff told us they had received specific training to enable them to meet the needs of people who used the agency. One social care professional confirmed that people in one supported living housing unit were supported by staff who had undertaken the required advanced training in dementia.

Nine out of 11 people we spoke with told us they had been involved in planning their care and how their needs were to be met. One person said: "Yes, they came and when we asked to increase the visits they came again and re-assessed. We asked them to come".

Staff we spoke with said they would inform the office staff if there were any changes in people's health or wellbeing. Most staff we spoke with said that if there were issues about the specific care being given then extra information would be incorporated into the person's care plan. Four staff we spoke with said there were often text messages or emails sent in relation to urgent changes in people's care that had been made. However, one member of staff said that it was: "…hit and miss" if changes in the care plans were made.

Findings from 18 December 2014 Focused inspection

People told us their preferences and choice were respected and acted upon. One person told us that their views were respected "very much", People we spoke with felt listened to and were very happy with the care they received.

We found that people's preferences had been respected For example, previously people had told us that they did not always receive the choice of female or male carer. However on this inspection we saw examples of where people's preferences were taken into account. When this was not possible we found that staff communicated with the person to explain and request their permission to use a staff member of a different gender. For example, one staff member was unable to complete their care calls due to an accident. This meant that only a male staff member was available to carry out the calls, staff contacted each person

Are services effective?

(for example, treatment is effective)

to check they were happy with a male carer. This meant that people's preferences and dignity was acknowledged and maintained where possible. We spoke to forty four people and people confirmed they felt listened to and staff respected their wishes.

All people we spoke with confirmed that they felt staff were properly trained and were happy with the support provided to them. One person said, "Carers are well trained." Another said, "Well trained and very helpful." Our findings on this inspection confirmed that staff were receiving the appropriate training and were well supported in their roles.

Are services caring?

Our findings

We spoke with 11 people about the staff who worked for the agency. Where people had care staff visit them at home we received mixed feedback. One person said: "I stated that there was one carer that I wasn't keen to have and now I find that I am having this particular carer at least three times a week. I don't mind having [the staff member] once but the one who has been particularly good has gone. Some of my carers are very pleasant; in fact most of them are extremely good." One relative told us: "I am upset that a carer [the person] has had for a year has been taken off [the person's] rota and it has depressed [the person]. The carer has been a very good and efficient carer and it is very upsetting. I thought the care of the service user had to be uppermost? I now have a carer that [the person using the agency] has not got on with since the beginning."

People we spoke with said they were not always told which staff member would provide their care, if the staff were going to be late or if there was a change to their regular care staff. One person said: "If they would just pick up the phone and call me and let me know. It was 10.15pm last week and we were desperate for bed." Another person said "The agency puts in a new carer but they don't tell me who is coming. I have a key safe on the door and any carer might walk in. They don't send a letter telling me who is coming. There is no rota telling me who is coming."

We found that people who lived in one of the supported living properties spoke highly of the staff. One person said: "They are charming and lovely people, almost faultless. They establish a good relationship with you." Another person we spoke with said: "Yes, I am treated with kindness, everyone has been really good."

When we asked people what they thought staff were good at, the comments were: "They do anything I ask", "Good at lifting X's [relative's] spirits, some are better than others", "Turning up".

There was information in people's files and daily records that showed the ways each person was supported and encouraged to remain as independent as possible in their daily lives. One person in the supported living home said: "I'm happy to be here. You have to do as much as you can for yourself [to remain as independent as possible]. If you want anything you only have to ask. We have a laugh." Another said: "If you wanted me to pick a 'best' carer I couldn't. They're all lovely. We all get on here [staff and people who used the agency]."

All the 11 people we spoke with said their privacy and dignity was respected by agency staff. People commented: "Yes, definitely: I feel as though I can say things in confidence and know that my personal care is not going to be trumpeted from the rooftops. I am never left completely naked." and "The blinds are always down and the carers normally shut the back door. They always cover her back up after washing."

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Findings from the comprehensive inspection of 10 April 2014

Nine out of 11 people said they did not know who would provide their care on a regular basis. People we spoke with said: "We don't always get the same carers; we don't know who is coming. We would like regular carers." Another said: "I don't have a rota; a complete stranger can walk into my house." We saw information in the customer survey form, which showed that almost 20% of those who responded felt they did not see the same staff regularly. We spoke with people who used the agency, who were also concerned about the number of different staff they had providing their care. Staff and people who used the agency said that access to staff in the office was often limited. One person said: "The phone is answered but they say they will ring you back and it doesn't happen. I tried three times to get hold of someone at the agency last week and they didn't come back to me. I am still waiting for them to come back to me. Communication is not good." This demonstrated that the agency did not communicate information that was important to people in a timely manner or involve them in the planning of their care. This meant there had been a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations and the action we have asked the provider to take can be found at the back of this report.

Two people expressed concern that staff who had cared for their relatives for many years were suddenly removed without explanation. We spoke with the manager who said that as the needs changed for people, (e.g. some people needed two staff to assist with their care), staff had to be available to meet those needs. The manager told us that this had been explained to the people involved. The manager said that assessments were used to try and ensure the person who used the agency had staff who were compatible and well matched with them.

The manager said that contingencies were in place when staff were unable to make the visits to people. However the agency's customer survey report for 2014 showed that 37% of people who answered the survey said the office staff did not advise them of changes in their service and 11% said the service was not reliable or responsive.

One staff member explained "The office [staff] have not always rung people, even if I have rung to say I am running late. It happens too often." One person told us "For the first time this morning I got a call from the office saying that my carer was going to be late, they should have been here at 9am, they came at 11am. They don't usually tell you." Nine out of 11 people we spoke with said they were not told when staff were changed at short notice. This meant people's safety was at risk because they did not know who would provide their care and their personal security was not consistently protected. This showed there had been a breach Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) 2010 and the action we have asked the provider to take can be found at the back of this report.

There was evidence that telephone monitoring had taken place between January and March 2014 to check whether the agency was meeting people's needs. The manager said there had been some minor issues that had been addressed immediately, but not concerns we had found during the inspection. Eight out of nine people we spoke with said they had answered questions about the quality of the service provided to them. However one person told us: "I had one which I refused to fill in. It was loaded to them. I wanted to be able to say exactly what I felt – this came from the head office. I didn't know how to fill it in so that it was accurate."

The manager said they had employed a member of staff when they took on a package of care for someone whose main language was not English. This was to enable the person to have some verbal interaction with, and information from, someone who spoke their language. This ensured that the person could have their individual choices and decisions recorded appropriately.

We asked ten people about whether they were aware of the complaints process. Only two people said they had information from the agency about how to raise concerns. One person told us: "I usually get through to the office. I don't know where to go. I don't recollect seeing it in the care plan, there are so many pages". There was evidence that four complaints had been recorded, and a full investigation had been completed for each. The action taken had been noted and it showed that the management team had dealt with the complaints. The manager said there had been problems when office staff had not communicated the issues raised by people who used the agency. This had been addressed by ensuring office staff

Are services responsive to people's needs?

(for example, to feedback?)

were aware of how to process complaints. The manager said lessons had been learned as a result. Any trends of complaints would be raised by the head office, where all complaints issues were sent.

Findings from 18 December 2014 Focused inspection

At our last inspection on 10 April 2014 we found concerns in relation to the way in which people had changes to their care visits communicated to them and that they were not always involved in the development of their care plans. At this inspection we found that communication had improved and people were starting to see the benefits of the changes made to communication with the office staff. We found that the issue of late arrivals and shortened care visits still existed. This was due to insufficient staffing levels within the provider and the provider had made the improvements to address the concerns in relation to respecting people's wishes and involving them in decisions relating to their care.

At the last inspection in April 2014 we found concerns in relation to people's experience of receiving visits from care staff that they did not know, this made people feel unsafe. At this inspection every person we spoke to said they felt safe and confirmed that the communication from the office when changes were made to the care staff visiting them, had significantly improved. This showed that the provider had addressed the concerns raised at the previous inspection and people's experience had improved.

People told us they were aware of the complaints procedure and we found 39 out of 44 people did know how to complain, most people said they had no reason to complain. We found people were happy with the care provided. We saw the complaints log and we found procedures were followed and complaints were fully investigated. We also saw many compliments paid to staff. One stated: "Thank you for all the support and such high standard of care, brilliant time keeping and politeness."

Are services well-led?

Our findings

Staff we spoke with said information was slow in being sent to them. For example one member of staff said: "There was a staff meeting 5 weeks ago but we still haven't got the minutes. We were told we would get them as soon as possible". There had been staff surveys in February 2013 and April 2014. Information in the staff survey in 2014 showed that staff did not feel supported by staff in the office with remarks such as: "…they don't really want to listen or help me", and: "…lack of caring attitude from the office." Two staff we spoke with said there had been some improvement but four others said there was still an issue. Although one staff member said: "Communication is good between the office staff, carers and clients", and another said: "Office staff are always on the end of the phone, although sometimes you don't get a response about an issue you raised." Improvements were needed so that staff felt supported and motivated. The manager said the staff were sent memos, newsletters and texts to keep them informed of developments within the agency.

The manager told us that relationships between the office staff and care staff was better than previously however people who used the service told us that communication with office staff was often a problem. One person said: "Communication, there is no communication at all. They really haven't got it together. May I stress, it is the management not the carers. Lack of communication and manners towards their staff can be improved a lot."

The agency had some systems for monitoring the quality of the service through monitoring calls to people who use the service and surveys. However these had not identified and led to improvements in the areas of concern we identified during our inspection when speaking with people who used the service.

All six staff we spoke with said they had received training in whistleblowing, had the phone numbers they needed and would raise concerns immediately. One staff member said: "I've never had to, but I feel it would be dealt with by my supervisor. If not I would go above her if need be". Another said: "I've done the training. I know what to do and there are policies and procedures in the office". There was evidence on the training records that staff had undertaken this training.

There was evidence that concerns, complaints, incidents and accidents had been used as an opportunity for learning. The manager said there was a monthly meeting between the branch and management that looked at trends and any actions necessary to improve the service. There had been one issue where a co-ordinator had not communicated information to a person who used the agency and lessons had been learned. Different practices and procedures were put in place as a result. There were also monthly meetings with the local council to discuss complaints or service issues.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Personal care	**10 April 2014** **Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010. Staffing** How the regulation was not being met: The registered person did not safeguard the health, safety and welfare of people who used the agency as there were not sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity. **18 December 2014** The provider was not meeting regulation

Regulated activity	Regulation
	10 April 2014 **Regulation 9 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services** How the regulation was not being met: The registered person did not ensure the welfare and safety of people who use the service as there were no individualised risk assessments. **18 December 2014** The provider was not meeting regulation

Regulated activity	Regulation
	10 April 2014

This section is primarily information for the provider

Compliance actions

Regulation 17 (2) HSCA 2008 (Regulated Activities) Regulations 2010. Respecting and involving people who use services

How the regulation was not being met:

People's views were not respected regarding the choice of gender of their care staff. The agency did not communicate information that was important to people in a timely manner.

18 December 2014

The provider is now meeting this regulation

Regulated activity	Regulation

10 April 2014

Regulation 9 (1) (b) HSCA 2008 (Regulated Activities) Regulations 2010. Care and welfare of people who use services

How the regulation was not being met:

There was no consistency or information about which members of staff would provide care for people who used the agency. Therefore the planning and delivery of care did not ensure their welfare and safety.

18 December 2014

The provider was not meeting regulation

Regulation 20 (1) (a) HSCA 2008 (Regulated Activities) Regulations 2010. Records.