Agincare UK Limited

Agincare UK Bridport

Inspection report

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Ratings

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

Overall summary

The inspection took place on 27, 28, 30 April 2015 and was announced. We gave the service a short notice of 48 hours as we wanted to be sure staff were in the office when we visited.

The service provides personal care and support to people in their own homes in the area of Bridport. At the time of inspection the service was being provided to 120 people, including older adults, some living with dementia and younger adults with physical disabilities or long term conditions. The service also provided care and support service for a small number of younger adults with learning disabilities. Approximately 60 people had their care plans arranged through local authority social care teams. Other people arranged and paid for the service directly with Agincare UK Bridport. The service is well established with over 1100 hours of care and support delivered weekly.

The service was required to have a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. At the time of inspection a registered manager was no longer in post as they had changed role to senior carer in December 2014. A replacement manager had been appointed who had been in post four months at the time of inspection. However during the inspection they were in the process of handing over to a new manager who had been in post for two days. The new manager told us they were in the process of submitting an application to become a registered manager. We spoke with both managers during the inspection.

At the last inspection on 5 December 2013, the service was not meeting the standard relating to the safe handling of medicines and not meeting the standard for how the quality of the service was assessed and monitored. At this inspection we found there had been improvements in how medicines were handled. People's medicines were handled safely as there was a system for recording, administration and checking to detect errors and for corrective action to be taken if required. Although there had been some improvement in how the quality was checked, there were still shortfalls in the area of assessing and monitoring quality.

People told us they felt safe with the service. We observed that staff reported their concerns promptly to the office. There had been a number of safeguarding investigations carried out within the service over the last year. The service had been working with the local authority over the last six months to address concerns found as part of these investigations and shortfalls in meeting contractual standards, found during their contract monitoring visits in June and August 2014. Concerns and issues found related to risk management and accidents, the quality of individual care plans and specialist training for staff relating to learning disability. These areas had been addressed; however some actions relating to care plans were in progress.

The service was not meeting the legal requirements of the Mental Capacity Act 2005 as the guidance was not fully understood and applied by the service. Although policies and procedures were in place relating to people who did not have mental capacity to give consent to their care plan, they were not being followed. This meant the service could not be sure the care and support being delivered was the least restrictive option to keep people safe, in accordance with the law and relevant code of practice.

People expressed mixed views about their service, with some telling us their experience was very positive and others stating concerns about timing of visits, communication or sometimes the skills and understanding of the care worker who visited. Some people wanted more consistency of care worker so they could know what to expect and build up a relationship with their carer. People who experienced some dissatisfaction with certain aspects of their service told us there had been gradual improvement over the last three months. One person told us, "we are very happy with care. We couldn't do without it. The carers who come to us are very kind." Another person told us, "girls I have are very good, the regular ones." Another person said, "the carers keep checking we are happy with everything. They provide good care." Another person told us, "I get very anxious about the way the care is delivered to me." We raised this with the manager who quickly responded to rectify this with the person. We observed examples of people being treated with respect by care staff and we saw office staff treating people with respect and consideration when they contacted the service by phone.

People told us that when they raised issues with their care that the office tried to respond and deal with it. For example, one person said they were, "always apologetic, and most times they do something about it, but sometimes they forget." Some people told us they were aware that it could be difficult when care had to be arranged when someone was sick. However some people did raise concerns about not always being notified beforehand if there were going to be changes.

The system for allocating visits took account of people's wishes and needs and where possible regular care staff were arranged who had the right experience to meet these needs. Office staff responsible for planning the service knew about people's individual requirements and tried to meet these by deploying staff who were suitably qualified. However the service acknowledged this could be constrained by availability of staff, which was affected by recruitment, and sickness, and were aware this affected people's experience of care. There was no

Summary of findings

system for the routine monitoring of the actual timings of visits against the planned times or for keeping track on how many different care workers went in to each person so performance in these area could be measured.

Some people relied on help from the service to eat and drink and we found that the most of the care plans we looked at described this support in detail and reflected people's wishes, however some were not as detailed. We found people who had been helped to eat a balanced diet. However the time allocated for this was limited for some people which affected staff's ability to always provide this consistently. The manager also acknowledged that some staff would benefit from more specific training in this area. Two staff told us they would have liked more time to prepare meals. Some people told us they would like more time for meal preparation however that their social worker was unable to arrange extra time for this.

People's needs were assessed before they received a service and written care plans contained a good level of information about each person and their preferences, the risks associated with their care needs and when a review was due. The new manager showed us a format which was being introduced to enhance care planning with people, to make it more person centred and give easy to follow guidance to staff about understanding people's wishes and preferences.

The service liaised with community social and healthcare professionals to ensure people had access to healthcare when required or to notify other relevant professionals of changes in people's circumstances. Staff were recruited safely. Staff received an induction and on-going training to carry out their duties. Most training was done online or through workbooks

Some people or their relatives told us the quality of their care could be improved in relation to the meeting more complex needs. The manager acknowledged gaps in areas of more specialist training for staff in areas such as dementia and other long term conditions such as Parkinson's. Staff told us they felt generally supported to do their job however some staff expressed a wish for practical training to help them meet individual needs confidently, such as moving and handling and catheter care.

The manager kept a record of feedback about concerns reported by people and staff and any action taken. This demonstrated people's issues were being addressed and their experience was taken into account in improving the service. Some staff told us the communication between the office and people and care workers had improved over the last few months, however that further improvement was required. The manager had visited some people at home to discuss their service, which people told us they greatly appreciated.

We found there were two breaches of regulation in relation to mental capacity and governance.

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?

Good

People felt safe with the service. Staff understood how to keep people safe from abuse and how to raise concerns.

Risk assessments were carried out and followed for individuals to promote the welfare and safety of people and staff.

Staffing was adequate to meet people's needs; however improvement was needed to ensure consistency.

Medicines management had improved and there was a safe system for people who needed help with their medicine.

Is the service effective?

Requires Improvement

Best interests' decisions were not carried out in accordance with the provider's policy. This meant the provider may not be protecting the rights of people who lacked mental capacity.

Staff received training and preparation before commencing work although some staff expressed a wish for more specialist and practical training. Some people said staff did not always understand their condition. This meant some people felt the service did not always meet their needs effectively.

People were supported to eat a balanced diet where the service was responsible for this, although people and staff felt some aspects of the service could be improved in relation to this.

Is the service caring?

Good

People told us their experience was that staff were generally caring and the service tried to maintain consistency of care staff for each person in order that trusting relationships could be developed.

Staff demonstrated sensitivity and care for people, however some people told us that a small number of staff did not have a caring attitude.

Is the service responsive?

Good

The service assessed people's needs with them and their families or representatives, and planned the service to meet people's needs. People had input into their care plans where their views and preferences were recorded.

Some people told us they would like more communication about any changes in their day to day care visits.

The service showed that they tried to respond to requests for flexibility however this was not always achieved due to constraints on staffing.

Summary of findings

People's concerns were recorded and acting upon when they contacted the service. People were called and visited from time to time so they could feed back about their experience.

Is the service well-led?

Requires Improvement 

The culture and ethos of the service was generally caring and people and families were listened to and concerns generally acted upon.

Quality checks were carried out however these did not capture and measure key aspects of the quality in relation to service delivery. This meant people's concerns were not routinely addressed.

Staff and people told us that although communication had improved further improvement was required to ensure the service was person centred.

The service leadership had been in transition since last year which affected progress on continuous improvement.

Agincare UK Bridport

Detailed findings

Background to this inspection

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

The inspection took place on 27, 28, 30 April 2015 and was announced. The provider was given 48 hours' notice because the location was an office base and we wanted to be sure staff were in the office when we visited.

The inspection was carried out by two inspectors. Before the inspection we requested and received a Provider Information Return (PIR) from the service. A PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also sent questionnaires to a random sample of people who were using the service and to a number of staff. We looked at this information before we carried out the inspection. We looked at notifications to the service and outcomes of investigations carried out under safeguarding procedures, reported to us by the local authority. We reviewed three local authority contract monitoring reports which had been completed in the six months before inspection.

We visited four people receiving a service and spoke with three relatives during these home visits. We spoke by telephone to seven people using the service and to one relative. We looked at seven care plans. We spoke with the outgoing manager, new manager and the regional manager. We spoke with a member of staff responsible for assessing and reviewing people's needs, and three members of staff responsible for coordinating and arranging the service and daily communication with people and staff. We spoke with six members of care staff. We spoke with two social workers who had been involved with people who used the service and with the local authority contract monitoring team.

We looked at a number of management records including policies and procedures, staff rotas and individual visit schedules for four people. We looked at five staff files and the service log of concerns, complaints and compliments.

Good

Is the service safe?

Our findings

At the last inspection on 5 December 2013, the service was not meeting the standard for medicines management. Some inaccurate recording of medicines given was found and there were incomplete records of medicines collected from the pharmacy, which could meant there was a risk of people not receiving their medicines correctly. We asked the provider to address this and they sent us a plan detailing what action they would take by when. At this inspection we found there had been improvement.

A system for issuing Medicines Administration Records (MAR) for people who needed support had been put in place which was audited weekly. One relative told us they had noticed errors with their relative's medicines three months ago. They brought to the attention of staff and management and told us this had been resolved. We found a detailed record of this on the person's care file. We noted another medicines error had been reported by a relative and this was investigated as a formal complaint. The complaint was upheld and resulted in appropriate action to prevent a repeat incident. The manager showed us the system for spot checking the competency of staff in administering medicines, including training materials used to deliver a refresher session to a staff member where any shortfalls were identified. This was effective as no further complaints were noted and one relative we spoke with told us the problem was addressed. Over 40 people were receiving assistance with their medicines. We found that each MAR was checked by the designated lead for medicines. They were responsible for ensuring that prescriptions were correctly recorded on the MAR and for updating the record and instructions had there been any changes of prescribed medicines.

We spoke with two staff about medicines and found they understood the correct procedures. We observed on a home visit, where someone had 'as required' (PRN) medicines the care plan included written guidance to staff about administering this. Where people needed topical creams applied, separate charts were in place and we saw they were used to record the prescription and instructions. We observed staff completed these charts in the home.

Feedback from people about infection control was positive with people telling us that staff followed hygienic practices such as washing hands, using the appropriate personal protective equipment such as gloves and disposing of waste appropriately. However one person stated that they found, 'one or two staff' visiting them did not clean and tidy after them. We spoke with staff who all told us they received infection control training. One member of staff told us they washed hands on arrival at a person's home and wore gloves and aprons. If dealing with medicines, creams and other such duties they told us they would wash hands before and after. They told us they made sure the person's home was left clean and tidy and that all waste was disposed of appropriately, however they were aware not all staff did this. We noted from minutes that this issue was raised in staff meetings, where the manager issued reminders to staff about the importance of this issue. We found based on speaking with people and staff that infection control practices were safe.

People told us they felt safe from abuse in relation to the service. One person told us, "staff look after both of us and there is no bullying or anything like that". Another person told us, "I am sometimes worried by my care as I do not always feel safe." We raised this with the manager who responded immediately and made appropriate changes to the way care was arranged. One person reported that they did not feel safe due to lists of key codes being left in their house. When we spoke with the manager they were aware of this incident and had taken action to remind staff of the importance to safety of confidentiality of people's personal data. One person told us they felt safe with the care provided. They told us staff used a hoist to transfer them and that they "felt safe".

Staff demonstrated they understood what how to keep people safe and how to raise concerns. For example, a member of staff told us, "If I had concerns I would raise them with the line manager. If serious I would raise a client concern form, that way our office has to act upon it and give me feedback and follow up." Staff told us that they would contact the office or on call person if they thought someone was in immediate danger. Staff told us that they would go to the area manager or to social services if they did not get a response to their concerns. One person's care record showed that four members of staff had appropriately raised and recorded concerns. We looked at the service log of concerns and saw that action had been taken in response to this, including prompting a review with the local authority social worker. All staff training in safeguarding was up to date according to the training record.

Good

Is the service safe?

Staff demonstrated awareness of specific risks for individuals. For example, some people presented a risk of harm to themselves due to self-neglect. Some people relied on the service visits for food and drink due to physical disability or memory problems and lived alone. Staff responsible for planning and arranging care knew about these risks and prioritised care visits accordingly. They were able to tell us which staff had the specific training or experience to meet people's needs or had a good relationship with the person. This knowledge and understanding was used to help plan the service safely and ensure people's needs were met. Staff and management acknowledged that the system for risk management would be improved by staff logging phone calls or events in each person's electronic record, as well as in staff notepads. The electronic records were part of a system used to plan and coordinate visit times and arrange changes as required. Management told us they had started to ensure that phone calls were recorded in this way to ensure a full picture of any changes or incidents which affected the person's care and support. The manager also told us that, following a recommendation by the local authority contract monitoring team, risk assessments had now been cross referenced with care plans. From our review of care plans we saw this had been done.

Risk assessments were included in people's care plan. For example, one person who we visited had a risk of pressure ulcers due to being unable to move independently and we saw there was a skin care risk assessment and plan of support in the care file, both at the office and in the person's home. We observed staff in someone's home visiting to provide personal care. When we spoke to the person following this we found that staff had carried out the care for the person as instructed, which included steps to reduce the risk of skin breakdown. Risks relating to people who lived alone and may not eat were written in the care plans we looked at, where relevant. One relative told us they asked for a food chart to be put in place. This was because they knew their relative did not eat much at mealtimes and they thought this should be monitored. The service had responded to this and we saw the person's food intake was now being monitored.

People's care and support was planned safely. Risks relating to the home environment were assessed in a standard organisational format. An initial assessment carried out on a home visit included health and safety for example relating to hygiene, layout of the home fire safety. The environmental risk assessment included consideration of the safety and welfare of staff and if issues were raised, instructions for a lone worker assessment to be completed. On the care plans we looked each had a completed environmental risk assessment document.

Staff were recruited safely. We looked at four staff files and found all appropriate checks in place, including previous employer references, checks on suitability through an application and interview process and check with the Disclosure and Barring Service (DBS) before appointed staff commenced work on their own.

Staffing was sufficient to meet the needs of people using the service however this was managed by some staff working high numbers of hours each week. The manager told us that staffing recruitment and retention was an on-going challenge for the service. There was only one report of a missed visit, which was investigated, appropriate action taken and a formal apology was made in person by the manager. The service acknowledged that people's service was sometimes late, due to the previous visit having taken more time than expected, but that risk assessment was used to prioritise visits where there was a time pressure. Staff told us they generally found they had enough time to carry out care, although there could be a time pressure when preparing food or when someone had an accident and needed extra help. People told us they were aware of these issues however that they could rely safely on the service.

Requires Improvement

Is the service effective?

Our findings

People's consent to their care and treatment was not always sought in line with legislation and guidance as set out in the Mental Capacity Act 2005 (MCA). This meant there was a risk that care was more restrictive than it needed to be for some people and their autonomy was not being respected. In two of the care plans the assessment of need showed the person had a mental impairment and would be unlikely to be able to give informed consent to their care. There was a detailed organisational policy including a template for carrying out MCA assessments and a 'best interest checklist and decisions record' however this had not been completed for these two people. In one of the care plans instructions to staff about how to deliver the care may have amounted to the person being restricted in their own home in order to keep them safe. This included having internal doors locked in their own home to prevent their access when they were alone. However no record of a best interest decision was made about this. We spoke with the management team who confirmed the 'best interest checklist and decisions record' had not been completed in respect of these actions carried out by care staff. In another person's care file, the daily log of care and care plan described how the person sometimes declined the care offered by care staff. Although a best interest decision had been made about one aspect of their care arrangements, concerning their residence and who could stay in the property, it did not cover all the personal care interventions set out in their care plan.

A member of staff was able to clearly describe their response in the situation where a person said 'no' and a relative told them to do something. They told us they would ensure the person receiving the service was consenting for anything to be done for them. According to the training record most staff had not had training in MCA. We spoke with the outgoing manager who although showed awareness of the company policy on MCA, was unable to describe the MCA framework and how this should be applied in a domiciliary care service.

This was a breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 (Part 3).

Staff received training both at induction when they were new and periodically received refresher training. According to the training records, nearly all of the mandatory training was up to date. Where there were gaps staff had been booked in complete their training over the next few weeks. Mandatory training completed by all staff included induction, health and safety, medicines management, fire safety, infection control, nutrition and food hygiene. One person told us they felt staff were competent to do their job. They said they were aware that staff received spot checks and said, "they have training quite often; they often get up-dates on what they are doing". Staff told us they received training before they started caring for people and were given opportunities to shadow more experienced staff following their induction. For example one member of staff told us they received training at induction, which was three days, followed by a number of shadowing shifts. They told us they had been spot checked, which included checking gloves and aprons were being used, how food was handled, that hands were being washed, if moving and handling was correct, and that the individual's care plan was being followed.

Most staff had not received specialist training in relation to specific conditions such as dementia and neurological conditions, which meant some people with these conditions experienced care that did not always meet their needs. For example, one person told us they felt they were not understood by some of the staff, in particular certain aspects of their condition and how it affected their day to day functioning. We raised this with the manager who took appropriate steps to address this with the person, by adjusting their care plan and how care and support was delivered to better reflect their preferences. A relative told us they thought staff needed more training in dementia care. They gave us an example of how staff did not always communicate effectively with their relative as they did not know different methods of communicating with someone who was living with dementia, such as using visual prompts. Three members of staff had received training in neurological disorders two years ago; however this was insufficient training for the workforce to respond effectively to people with these conditions.

We heard positive feedback about people's experience of the service. Four people told us their care was good. For example, one person said, "they always seem to know how I am." One member of staff told us someone was unable to communicate verbally they would try to do sign language, and "some may be able to read". They said that the care plan will say how a person communicates, and include what the service user has gone through with the supervisor

Is the service effective?

or a member of the family will have done this". The management team acknowledged improvement was needed in how staff acquired skills to support people with communication difficulties.

Most staff told us they felt supported and had regular supervision. One member of staff told us they did not have regular supervision. Most staff told us that communication had been improved in the last three months between them and the office and management, however that this still needed more work to ensure people were kept informed of changes to their service. Staff were supported to achieve professional qualifications and we saw from training records that nearly all staff had either achieved relevant qualifications or this was in progress. Spot checks were made on staff up to twice a year to check on how they were delivering the service. We saw this included whether staff followed the care plan and correct procures for medicine and how they responded to the person. The supervision of staff helped to ensure people received an effective service.

Some people receiving the service needed help with a catheter. Staff told us they received training in catheter care, including an information pack. One staff member told us they were shown at induction in a basic way, and then shown properly whilst doing shadowing shifts. Three other staff we spoke with could tell us about the basic procedure for this care. Three members of staff told us they would like more specific training where they encountered conditions or needs they were not familiar with. They said this was because as even if experienced; they may not be aware how to meet all needs. For example, one staff member said, some people's moving and handling might be quite complicated and you need training to gain your confidence."

We recommend that the service consider best practice in the area of dementia care and care for people with neurological conditions and consider any additional training needed by staff.

Some people were being supported to eat and drink as part of their care plan. Of the seven care plans we looked at, four people needed help with meals and drinks. Where they did not need support the care plan recorded how they managed their meals, either by themselves or stating that a relative provided this support. Detailed descriptions of what people liked to eat for each meal, including any supplements were included in people's care plans. We looked at whether staff had training in food preparation. Most staff had completed food hygiene training however did not have specific training in cooking. Although staff did not tell us this was a problem, some people felt their meals could be improved. For example, one person told us they would like better food at mealtimes. The management team acknowledged that some staff may need more training in how to cook, dependent on their previous experience. One member of staff told us they cooked a full meal for some people, however did not find this a problem as they had significant previous cooking experience. One person used specialised feeding equipment and we saw certificates for six staff allocated to visit, showing each had attended specialist training to use it safely.

Some people told us they would like more time for food preparation. A member of staff responsible for reviewing the care plans told us most people had enough time allocated for food preparation but not all did, which could make it difficult. This meant that staff could not always prepare the meal chosen by the person. When we spoke with the management team, they were aware of this issue however stated that it had been challenging to get care plan timings changed if they were commissioned by the local authority, due to restrictions on budgets. We confirmed with the local authority that people were not allocated time for care staff to cook meals from scratch and this was a limited provision within a package of personal care. For example, someone would be encouraged to find other ways of providing for their meals such as the use of ready meals or delivered meals.

People were enabled to get access to healthcare services as appropriate. The service was aware when to seek advice on people's behalf with their consent. For example, we spoke with one person who told us they were supported to get an appointment with their GP. Staff were able to tell us about the roles of community healthcare professionals such as community nurses and occupational therapists in assessing and supporting people, and give examples where they had contacted them for advice. In the six months before inspection, on two occasions the local authority carried out safeguarding investigations following accidents to people and found that there had been shortfalls in action taken by the service in response to accidents. We saw evidence the staff had been sent updated guidance over the last three months about the protocol and criteria for contacting emergency services.

Good

Is the service caring?

Our findings

Staff demonstrated concern about people and the service tried to meet people's needs for continuity, by ensuring the same staff were allocated to each person, although this was not always possible. The service tried to ensure people had continuity of care so they could develop a relationship with their care staff. They acknowledged where this was not always possible this could affect the consistency for people. One member of staff told us they visited a "core set of people you go to; they get continuity and you know the routines and can get a rapport with the person, clients get to trust you, and trust in you".

One person spoke very highly of their care workers however stated they did not find all the care staff knew her as well as her regular care staff. Another person told us, "I have four or five regular carers who I am really pleased with, the help each other, it's very good". They told us if asked to do something the care staff always did it. We looked at the visit records over the last six weeks before inspection for four people who received over two visits a day seven days a week. We found for one person with complex needs a good level of consistency with only three changes of care staff.

We saw for two people who preferred a male care staff that this was consistently provided. The other visit record showed some consistency with six changes of care staff over six weeks.

People were treated with respect and consideration. One person told us that staff helped her to be independent and treated her with respect. They stated about staff, "they wouldn't do anything I didn't want them to". A member of staff told us "I basically treat people how they want to be treated, I listen and respect what people want to do, and do not impose anything, and let them do things their way, unless there is a risk". Another member of staff told us "they are in control, it's not we go into their house and take over."

We observed two staff treating people with respect and kindness. They ensured their privacy was respected by shutting the door when personal care was being given. The person and their carer told us they trusted the service to be there for them, relied on them and described a caring bond between them and their regular care staff. One person's relative told us, "I get all the help I need; all the staff are respectful to me." A staff member told us how they promoted the independence of the carer and enabled to them to continue caring for their relative in line with their wishes. The relative, who was a carer told us how the members of staff from the service had gone out of their way to enable them to cook a special meal for their relative.

Good

Is the service responsive?

Our findings

People's needs were assessed before the service started. One person told us, "I had a very good interview, and the assessment was thorough." Another person told us at the start of the service they had got all the information they needed and they "were very satisfied with the service".

They said there was a care plan in place which, "the carers use if not sure of anything", "but most know the procedure". There was a system for assessing people's needs with them and producing a detailed care plan to a standard format. This contained information which helped the service to understand and meet people's needs. Some care staff told us they thought improvements could be made so that detailed information was made easier to read for them when they were short of time and had not met the person. The manager told us they were reviewing how the service could develop the care planning system to be more person centred.

People's views about their care were recorded and their care needs were expressed in the first person on the care plans, including their preferences, likes and dislikes. One person told us they were able to make their own choices, and when it involved things they needed assistance with staff listened. Staff told us that the information they needed was included in the care plan. One staff member told us, "it is broken into steps but it may need reordering after we've visited the person and spoken to them, to get it right." Another member of staff told us if they were visiting someone new they tried to speak with the staff who knew the person so they could get the service right. A relatively new member of staff told us they did have time to read the care plan when visiting someone; however they also asked the person how they liked their care to be delivered.

Changing needs were picked up. Staff told us that if someone consistently required more time than the visits allowed, they would let the office know and they would ensure this was arranged. One member of staff demonstrated how they responded to someone on different days. They told us when one person they were visiting on some days did not express themselves verbally, because they were tired and frail, they would observe their expression to know what they liked and disliked. We saw in the daily notes of two people that staff paid consistent attention to noting people's moods and wellbeing, recorded choices offered and how they responded, reflecting an on going responsive and sensitive attitude. Staff attitudes and skills in observing and adapting to people's mood helped to ensure responsive care.

People's views were varied in relation to the flexibility of the service to respond to their needs. People told us their care was generally carried out as required however lateness or changes to their care worker was sometimes a problem for them. Although care was delivered, it might not have always been how people wanted it. For example, one person told us "they are having difficulty with a changeover of staff, staff sickness and they have to fill vacancy". They said, "it's not their fault, they do substitute someone, but about half an hour later". One person told us they requested consistency of staff, and that they helped train new staff, which they were happy to do so they understood their preferences. However they told us, "there is no system to make sure things are done," and gave examples of when they wanted a different time for a visit, or had a change in number of staff needed because other carers were present. They stated that communication from the office could be improved", in relation to being informed about changes to their service, for example a last minute change to the care staff visiting that day or if the service was running late. The manager told us they had worked on this issue over the last three months, reminding the relevant staff of the importance of this. They told us they were aware from feedback that this was an issue for people. we saw from the records relating to February, March and April 2015, that people expressed a common concern about being informed if their visit was going to be late and also that they wished to have the written visit schedule on time. People received a weekly list informing them who was visiting and at what times. One person said there were delays with this sometimes. Staff said this had recently improved as before last month or so, people did not always get this. They told us "I believe the sheets now get sent out by Thursday lunchtimes so people have the opportunity to say if they don't like that time or carer."

A record was kept of people's concerns as well as a formal complaints log. We noted the formal complaints log did not include some of the concerns we had heard from people. The manager told us that not all concerns were taken to a formal complaint level. However the management team regularly contacted people to find out what they thought about their service. From our review of these records we saw that the majority of people contacted were recorded

Good

Is the service responsive?

as stating there were no problems or that the service was good. The manager told us they used this feedback to improve the responsiveness of the service. Examples included contact between the office and staff and people to ensure any changes to the service were passed on to people as appropriate.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection of December 2013, we found shortfalls in how the service assessed and monitored quality. At this inspection we found there had been some improvement however this area needed to be addressed further to ensure the standard was met. The assessment and checking of quality however was not effective in capturing key issues of quality in the service. For example, the issues people raised about their visit times and having regular carers was acknowledged and action has been taken to address this. However as there was no system to routinely measure call times or numbers of carers to each person, there was no performance measurement in this area. People told us these aspects of the service were important to them.

The inspection found the service was meeting the needs of a number of people with complex needs, some in challenging circumstances. The service did not keep a service overview of the needs of people, such as how many people lived with dementia or other long term conditions or how many people lacked mental capacity to make certain decisions. This meant the service did not have the right information to determine the training requirements of the workforce. The gaps in staff skills in relation to particular conditions such as dementia had not been picked up through audit. This meant that some people experienced care that did not always meet their needs because staff could always not understand them.

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

The changes in registered manager meant that leadership was still in transition at the time of inspection and the service had been without a registered manager for four months. Some improvements had been made in response to shortfalls in standards identified at the last inspection and from local authority contract monitoring visits and safeguarding issues. A small number of people with learning disabilities were being supported by the service. Over 2014, the local authority monitoring the contract for this service, repeatedly requested that identified gaps in training were addressed by the service. This had started to be addressed over 2014. The manager showed certificates in relation to a number of staff who had received epilepsy and challenging behaviour training over this period, including training provided by the local authority. Staff responsible for arranging the care were able to identify these staff and had used this knowledge to match them with people as appropriate. Care plans had improved in detail and content. Risk assessments had been cross referenced within each care plan. Some staff had received specialist training in areas related to learning disability and these staff were being matched appropriately to people with leaning disability. Although there was an action plan in place for improvement related to the local authority contract, when we asked if there was a more detailed plan for future overall quality improvement this was not available.

The governance of the service was supported by a large organisational resource in respect of training, recruitment and policies and procedures. A standard set of monitoring was required to be to be submitted by the local branch manager to the head office. Various audits were carried out by the manager which helped to monitor some aspects of service delivery, including information on the volume of service being delivered, assessments and reviews, incidents and accidents. This helped the service understand some important aspects of service performance. In addition the service kept a local log of concerns which helped to ensure people's feedback was captured systematically and used to improve the service. Staff had completed a survey as part of an organisational wide survey of staff. The outgoing manager told us that the results of this had not been sufficiently mapped to branch level to inform staff welfare and support at local level.

There was in general a positive and caring ethos within the service, expressed in people's feedback and in comments from staff. All staff we spoke with appeared motivated to provide a professional, effective and caring service. Some staff told us they would like more feedback on what they were doing to feel valued. Communication between staff and between people and staff was commented upon by both as having improved over the last three months as a result of actions by the new manager, but still needing further improvement. Staff meetings were held regularly between staff and management. Notes from the staff meeting of April show how meetings were used as opportunities to remind staff about compliance with polices, planning the service ahead, and passing on positive feedback.

Requires Improvement

Is the service well-led?

People and their families made regular contact with the office. One person told us, “they know I will tell them if there was a problem”. We noted that the office premises did not provide a reception area for the people who used the service or their families or representatives to visit and discuss the service face to face. Staff facilities at the premises were also limited. For example, there was no quiet space and privacy for supervision, phone calls or training to take place. Four people we spoke with told us they had spoken with the manager face to face or on the phone. One person said “I received a visit from the new manager -she was very good and went round to meet all the clients and all the (staff)”. They said “she came round to see how I felt about things”. They said they knew the old manager was leaving and that a new person was now appointed. Risks to the safety and continuity of people’s service, for example due to weather conditions or staff illness were being mitigated through business contingency planning, led by the new manager at the time of inspection.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements were not being met and we have asked the provider to send us a report that says what action they are going to take. We did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **How the regulation was not being met**: Arrangements for protecting people's rights were not being fully implemented. This meant some people may be having care which was not in their best interests. Regulation 11(1) (2)(3)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: Systems and process for measuring and improving quality were not effective. Information about key aspects of the service was not routinely gathered and used to improve the quality of the service. This meant people did not always receive an effective service. Regulation 17(1)(2)(a)(b)(f)