Bluetulip Associates Ltd

Home Instead Senior Care - Luton & Central Bedfordshire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Home Instead Luton in July 2015 and rated the home as Good. When we revisited the service in January 2018 we rated the service as Requires Improvement overall. This is the first time Home Instead Luton has been rated as Requires Improvement since the service was registered in 13 December 2012. This inspection was announced.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults.

Not everyone using Home Instead Luton receives the regulated activity; the care quality commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

At the time of this inspection Home Instead Luton were supporting 56 people.

There was a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. There was also a day to day manager at the service. For the purpose of the report this person will be referred to as the manager.

People had risk assessments and care plans in place but these did not always capture people's needs. These plans lacked information to fully guide staff when they supported people. These plans also did not clearly state or had enough information to always help staff understand the risks which people faced. Staff did not always have clear guidance when supporting people who were a risk of falls.

Training which staff received did not always cover areas relevant to the people they were supporting. The management team were not checking if the training had always been effective and did not check staff had retained key information important to their work.

The competency checks completed to see if staff were competent to work independently after their induction and during their time at the service were not robust. They did not evidence that it was a robust competency check or how the assessor reached their decisions.

The services auditing processes were not robust because they had not identified the issues which we had found.

These issues constituted a breach in the legal requirements of the law. There was a breach of Regulation 12, 18, and 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.You can see what action we asked the provider to take at the back of the full version of the report.

When we spoke with people and the staff we found out that there had been some recent shortfalls in the delivery of care. Some people's care visits had been cancelled due to staffing levels. This was not everyone's experience but it had affected some people's confidence that they would receive their care visits. Some people told us that they had not received rotas and their regular staff had left or had told them they were planning to leave. Some staff felt under pressure to work additional hours. The management team said they were not aware of these issues.

The management team did not have an effective contingency plan in place, to manage situations when there was a reduced number of staff, available to support people.

Staff had a limited understanding about what could constitute a potential safeguarding event. Staff were also not clear about how to protect people from discrimination.

Auditing processes in relation to people receiving their prescribed medicines identified shortfalls in staff practice, but the solution provided was not effective. Nor were these issues identified in a timely way.

People said they were supported by staff who were consistently kind, thoughtful, and caring. Both the people who received support from Home Instead Luton and staff said they had got to know each other and formed good relationships with one another. Staff were very clear about how to treat people and their homes in a respectful way and how they ensured people's dignity and privacy was protected.

The registered manager said they were committed to improving the service and later sent us an action plan which outlined what action they were taking and planned to take to correct the short falls found at this inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service needed to make improvements to always be safe.

Staff knowledge about protecting people from potential abuse and harm was limited.

Staff understanding about discrimination was limited.

People did not have complete risk assessments which guided staff.

There were recent concerns about staffing levels.

Is the service effective?

Requires Improvement

The service was not always effective.

Competency checks on staff practice were not robust enough.

There were shortfalls in the training staff received.

The service did not always clearly capture people's consent to speak with other agencies. People's capacity assessments were not evidenced.

People received appropriate support with food and drinks.

Staff advocated on people's behalf to receive support from health services.

Is the service caring?

Requires Improvement

The service was not always caring.

People's confidential information was not always secure in the services office.

People said staff were consistently kind, caring, and thoughtful towards them.

Staff had enough time with people when they supported them.

People were treated consistently with respect and staff were polite to people.

People's dignity and privacy was promoted when they received care.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People did not have thorough reviews of their care.

There had been some recent shortfalls in providing care visits.

People said when staff supported them they responded to their needs.

Staff responded when there was a change in people's needs.

Is the service well-led?

Requires Improvement

The service was not always well led.

The services' quality monitoring systems were not effective.

There were concerns about the delivery of care which the service had not identified and responded to.

The registered manager responded to the issues we identified.

The service had made links with the local community.

Home Instead Senior Care - Luton & Central Bedfordshire

Detailed findings

Background to this inspection

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

The inspection was announced. We gave the service 24 hours' notice of the inspection. This was because we wanted people's permission to talk to them before we telephoned them. The inspection started on 16 January 2017 and ended on 18 December 2017, taking three days in total.

The inspection team consisted of one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. In this instance the expert-by-experience had personal experience of using this type of service.

Before the inspection we made contact with the local authorities' contracts team and safeguarding team. We asked them for their views on the service. We looked at the notifications that the registered manager had sent us over the last two years. Notifications are about important events that the provider must send us by law.

During the inspection we spoke with 14 people who used this service, and six relatives. Eight members of staff. The registered manager and the day to day manager. We looked at the care records of five people, the medicines records of five people and the recruitment records for three members of staff. During our visit we

also reviewed the quality audits, training program, complaints and the compliments about the service.

We received a Provider Information Return report. This is information we require the provider to send us at least once annually to give some key information about the service. What the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in the report.

Requires Improvement

Is the service safe?

Our findings

We last inspected Home Instead Luton in July 2015 and found they were providing Good safe care. However, when we inspected in January 2018 we found there were some areas where improvements were required.

During our inspection we identified an issue relating to people's safety. A member of staff told us that when they first went to provide support to one person, there was no risk assessment in place for that person. They were concerned about how to assist this person safely to have a wash. They made contact with the office and told us that they did not receive useful advice. They said that they were told to, "Find your own way." This member of staff said that they did not feel the person was safe, when they supported them in this way. This member of staff said that they found this situation very distressing.

The sample of care records we looked at had environmental risk assessments in place. These were to check it was safe for staff to provide care in these environments. We found there was a good level of information in these assessments. However, we noted an issue regarding people who had a risk of falls and used walking equipment who needed support with personal care. It was not evidenced if their bathroom or room where they had a wash could accommodate their walking equipment to prevent a fall. There was no guidance for staff about how to manage this risk in these people's care records.

The lack of robust risk assessments in relation to keeping people safe constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff knowledge of how to protect people from potential harm and abuse was not strong. We spoke with eight members of staff and only one was able to tell us the different types of abuse people could potentially experience. We guided staff about answering this question but still staff were not aware about the potential signs which could indicate if a person was experiencing harm. One member of staff said, "Oh you have put me on the spot." Staff should have a clear understanding of what abuse and harm could look like. Seven members of staff we spoke with also did not know about the outside agencies they could report their concerns to. Staff said they had covered this in their training but did not know. One member of staff said they would call the hospital, but this is not correct. All staff said if they had concerns they would tell their supervisor or the manager at Home Instead Luton. We concluded that the understanding by staff about this important area needed improving.

We also spoke with staff about how to protect people they supported from discrimination. Again staff struggled to talk to us about this subject. Seven members of staff did not link the fact that people they supported could be discriminated against because of their age, race, religion, gender or other protected characteristics. Two members of staff said they had not received training in this area. As a result of these responses from staff it was evident that staff knowledge of this area also needed improving.

During the inspection we looked at a sample of five people's records. We could see that people had risk assessments in place. However, these were not always complete and fully explored the risks which people

faced. Two of these people needed support each day with particular medical continence equipment. These people's records lacked guidance for staff to follow about how to do this. They also did not clearly outline the potential risks of infection, how to identify this, and prevent it. Another person made certain life style choices which were a risk to their safety and the safety of the staff, who supported them. This risk was not identified fully with a plan of action to support staff to keep this person and themselves safe at these times.

We were told about one person that the management team were concerned about. They believed they were at risk of experiencing neglect. This person was refusing care which meant staff were not able to monitor an important health condition they had. We spoke with the manager about this who told us what action was taken to try and resolve this issue. However this was not reflected in the person's assessments and reviews. This risk was not identified and explored in these documents.

During the inspection we asked people if they felt there was enough staff to provide care visits and we had a mixed response. Three people told us that there were times over the last two months that there was not enough staff. They told us that care visits had been cancelled the day the care visit should have taken place. They said they were asked if they 'could manage.' One person said, "Until Christmas I would have told you that I've never experienced any missed calls in all the years I've been with the agency, but since then, unfortunately things have gone a bit downhill. I've now had three teatime missed calls. When the agency has called me to explain, they have told me that they've been short staffed and I've told them I can manage because, I can just about do a sandwich for myself."

Some people said that their regular members of staff had left or were thinking of leaving the service. They said, "Everything was working well until Christmas, and since then a number of my regular carers have left or are talking about leaving. It is quite an anxious time for me because I don't cope well with lots of different carers."

When we spoke with staff we asked them about this issue of staffing levels. Out of the eight members of staff we spoke with three said that there had been times over the last two months when some care visits were cancelled. One member of staff said, "This is always the last resort." Another member of staff said, "It makes you feel awful, like you have let them (people who received care) down." One member of staff said they felt under pressure to complete additional care visits. Another member of staff said they were aware other members of staff felt under pressure to provide additional care visits, when they did not want to.

Alternatively other people told us that they did see regular staff at their agreed times and staff were rarely late for a care visit. For example one person said, "I would say that probably 95 percent of the time, my carers arrive within 15 minutes of their due time." When we visited the service's office we sat near the care coordinator. We noted that from 09:30 – 17:30 two care visits had been cancelled following a conversation with the people involved.

We spoke with the manager about this issue of staffing levels. They said they were not aware of a lot of staff leaving or being short of staff. We later spoke with the registered manager who said they were now recruiting more staff and reviewing how they scheduled care visits.

We concluded that there were some issues with staffing levels. This had the potential to undermine people's safety. The way this had been managed by the management team until now was not effective.

During the inspection we looked at the 'contingency plan.' There was no clear information and guidance to follow if there was a sudden reduction of staff. We spoke with the manager about this. They told us about how they recently responded to the recent severe weather. They talked to us about a system they had

created which highlighted the most 'at risk' people they supported. However, the contingency plan did not explain this. The plan did not guide staff or the management team step by step about what would happen if there was a sudden reduction of care staff. There was also no evidence to say the plan was reviewed regularly and shared with the staff and management team, who would have to respond to such a crisis. The registered manager said they would address this issue.

When we visited Home Instead Luton's office we looked at the recruitment checks of three members of staff. All three members of staff had a complete history of their employment to date. All three members of staff had two references and two character references. These staff also had Disclosure and Baring Service (DBS) checks in place before they started to provide care alone. Two of these staff records had two copies of proof of their identities, but one member of staff only had one. These are all important safety checks to ensure people are safe in the company of staff.

At this inspection we looked at a sample of five people's Medication Administration Records (MARs). We could see that there were times when staff had not signed to say if a person had received their medicines. This had been identified by the member of staff who completed the audits of people's MARs. However, this issue was still taking place, despite staff being made aware of this practice issue. These MARs were also not being audited until two months after these records had been completed.

The manager told us that senior staff regularly checked people's MAR charts when these records are in people's homes and completed an audit of their medicines at that point. This was to ensure the appropriate number of medicines had been administered. However, these checks and audits were not recorded and evidenced. These missed signatures were not being identified until the office audit took place. The fact that the audit of these records, in people's homes were not documented audits, meant we could not see how robust these audits were.

In one person's record we saw that a person had run out of a particular medicine, and went four days without it. We could see that some action had been initially taken. However, this issue had not been shared with the office. The manager had later identified and investigated this event. A plan was put in place to try and ensure this did not happen again.

There were records which confirmed that staff received a detailed competency check when they supported people with their medicines. Some of the staff talked us through how they gave people their medicines in a safe way. People told us that staff ensured that they had their medicines. One person said, "I know what my medicines are for, and my carer just has to pass me them and give me a glass of cold water so that I can take them. [Member of staff] always writes up the records as soon as my tablets have disappeared."

We concluded that when issues were identified regarding people's medicines the processes to quickly and robustly respond to these issues were not effective, and needed improving.

The staff we spoke with told us about what they did to ensure people were protected from infection. However, eight people said that the staff who supported them, did not wear disposable aprons, but they did wear disposable gloves. The eight members of staff we spoke with said they wore both disposable aprons and gloves. We asked the manager who said that they understood that staff did wear both of these items. One person said, "When they're (staff providing personal care) I do expect them [staff] to wear an apron. Many of them do, but just a few don't, unless I say something."

Requires Improvement

Is the service effective?

Our findings

Following from our inspection in July 2015 we found that the service was providing Good effective care to people. At this inspection in January 2018 we found there were some areas where improvements were required.

All the staff spoke positively about their induction to their work. Some staff we spoke with had not worked in a care service before. When they completed their induction they said that they felt confident to work independently. New staff had four to five days of training in a class room setting and on line. This was followed by two days of shadowing experienced senior members of staff. After this point staff worked independently if they felt ready to do so. At this point for the next twelve weeks new staff would complete the 'care certificate.' This is training which outlines what good quality care looks like. After this new staff were observed by a senior member of staff and their practice was assessed to check they were implementing their training.

We looked at what systems the service had to check if new staff were competent in their work after their inductions. We saw records which senior staff completed to check if staff were ready to work independently. These records had very little information in them. There was no set robust competency check list for the assessor to follow to see if new members were effective in their work. We found one competency record which said, "No issues found" another which had no information recorded on it. The service was not evidencing staff were ready to work alone.

During the inspection we also saw records which showed that staff had competency checks during the year. We looked at some of these documents. These had a comprehensive set of areas and questions for the assessor to respond to when observing staff practice. However, the assessor was not evidencing how a member of staff met individual competencies. We were told that competency checks took place twice a year. When we looked at these records this was not consistently the case. New staff also did not receive a further check on their practice potentially for 12 weeks after working independently. New staff said they felt they could seek support at any time. However, this system relied on new staff identifying if there was an issue. We concluded that the service needed to improve how they monitored and evidenced staff competency.

Staff received training in key areas in their induction such as, health and safety, safeguarding, first aid, moving and handling. Some staff received training on catheter care. When we looked at the training for new staff who completed the 'care certificate' we noted there were frequent times that some staff's scores for individual subjects were low. Sometimes these were below fifty per cent. We spoke with the manager about this who said that these members of staff would sit with a member of staff who has been assigned 'training' as part of their role with the service. They would then go through this training subject together. However, this was not evidenced with a new score obtained.

During the competency checks and staff supervisions, staff were not being asked additional key questions to

test their knowledge in important areas. We found staff struggled with areas of protecting people from harm and abuse, and discrimination. Despite this being covered in people's inductions. Some staff we spoke with were new to their role and would have recently completed this training. This questions how effective this training was.

We spoke with the manager about the training program who said the registered manager wants to create a culture of continuous learning and a centre of excellence. New training topics had been identified such as end of life care and dementia care. The management team was starting to look into this. However, these and other health conditions were currently relevant to the people they were at present supporting, and training in these areas had not been considered before.

The above issues constituted a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people we spoke with all were complimentary about staff when we asked them if staff had the skills and knowledge to do their job. One person told us that, "My [continence equipment] can be quite fiddly, but the carers take their time with it and they always double check it, last thing before they leave." Another person's relative said, "My [relative] has needed two carers because [my relative] needs to be hoisted. I have been really impressed with how the carers do this. They talk through everything with [relative] and my [relative] says they are comfortable and happy. The carers are really patient with my [relative] and in my opinion go out of their way to ensure [relative's] safety."

We concluded that the training system in terms of the timing of the training and how the management team checked if the training had been effective was not robust. This was not being effectively monitored.

People told us that staff supported them with their food and drinks. One person said, "My carers always make sure that I have plenty of hot drinks and they will always leave me with a drink just before they go." Another person said, "My carer mentioned to me that I was struggling to prepare my own breakfast, so they asked me if they could tell the office and look at getting me a bit more help."

The staff we spoke with explained to us how they ensured people had enough to eat and drink. Staff said they assisted those people who needed encouragement to eat and did not leave food in front of people if they needed support to eat, whether physically or with the motivation to eat. One member of staff said that they noted one person was struggling to eat and needed more support to do this. They spoke with the office staff who spoke with this person's relative and additional time was given. They said, "I now sit with them, encourage them, and help them hold the spoon." Another member of staff said that a person had told them that they had tired of the breakfasts they were having. This member of staff said they called the office, to ask the relatives, to buy a wider selection of breakfast options for this person.

Staff supported people with their day to day health needs. When we looked at a sample of five records we saw that staff consistently raised concerns about people's health needs. We saw that staff contacted the office staff and these members of staff spoke with people's relatives and health professionals. One person had returned from hospital with a pressure sore. We saw records which showed that the office staff were liaising with the appropriate health professional to raise their concerns about the management of this sore. We noted that a member of the office staff had to on one occasion proactively encourage action from a health professional in order to help this person get better. We also saw examples of a member of the office staff following up health referrals and checking progress when no progress regarding this issue appeared to be happening.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

When we spoke with staff they gave clear examples of how they promoted choice with people's day to day needs. Such as offering people different options for their lunch and showing people these options. Seeking consent and asking people what type of support they wanted with their personal care. The people we spoke with confirmed this happened.

One person said, "The carers help me (with my lunch) by telling me which choices I have on any one day, so that I can decide what I fancy eating before they put it in the microwave to heat up." Another person said, "Some mornings I don't always feel like having my shower as soon as they get to me. In that case, my carer will usually make me a hot drink and see if I want my breakfast whilst I wait a few minutes ahead of having my shower."

We noted that people or their representatives were asked to sign a consent form before care visits started. We found that it was not clear on this form that staff would be making contact with social care and health professionals on people's behalf if they had concerns about people's needs. When relatives signed this document on their relative's behalf there was no accompanying documents to show they had the legal powers to do this. Given the degree of information sharing with health and social care agencies the service was doing, this needed to be clearer. The registered manager said that people are always asked first if they can call a person's GP for example. However, this was not evidenced in the sample of people's records we looked at.

In people's care assessments it stated that people were able to make day to day decisions for themselves. However, it did not say how the assessor had reached this decision. Capacity assessments about specific decisions when people's general assessment took place were not routinely taking place. When we asked staff to tell us what 'mental capacity' meant to them in terms of their work with people, all the staff we spoke with struggled to answer this question. When we looked at the staff training program there was no specific training on mental capacity.

We found that staff were compliant with the MCA in terms of their practice, but we concluded that there were other areas in relation to consent where the service needed to make improvements.

Requires Improvement

Is the service caring?

Our findings

When we inspected Home Instead Luton in July 2015 we found that the service was caring. When we visited the service in January 2018 we found that there was evidence of a caring service. However, we identified an issue relating to people's private information which undermined the service's rating in this area.

During this inspection we found that people's private information was not always being protected. When we visited the service's office we found a large collection of people's daily notes and MARs on a member of staff's desk. They confirmed that this information is left on the table to process. The service's office had a long corridor going through it which was open to other people who worked in the office block. These were businesses which were separate to Home Instead Luton. We saw people using this corridor during our visit. On occasions the large TV screen showing people's names and if a member of staff had visited them was on display. A room containing people's care records was at one point unlocked. We spoke with the registered manager about this. They told us that action will be taken to address these issues.

People spoke positively about the staff who supported them. One person said, "The other morning one of my carers noticed that I was getting a bit of a cough so she asked if she could pop over to the shop and pick me up some cough sweets, as I hadn't got any in the house. That was so considerate." Another person said, "They [staff] never say 'no'. If I'm running out of milk and bread, they'll often pop across the road to my local shop for me. Sometimes it's them that realise I'm running short, before I do. I'm very grateful to them." A further person said, "[Member of staff] warms my bath towel on the heater so I stay nice and toasty."

When we spoke with staff some gave us examples of how they had built a professional relationship with the people they saw and promoted their wellbeing. One member of staff said, "[Person's name] tells me I'm worth nothing, I say of course you're not, and we talk." All the staff we spoke with said they had enough time with people. To talk and listen to what people wanted to talk about, to explain their actions and involve them in decisions about their care.

Alternatively some people were concerned that some of their care visits had been cancelled and they were not seeing regular staff. Despite these concerns these people spoke positively of the staff and how caring they found staff to be. When we raised these concerns with the registered manager they sent us an action plan about how they were going to address this staffing issue.

Out of the eight members of staff we spoke with six said that they consistently saw regular people. These members of staff told us how they had got to know these people. They told us about the people they visited. When we looked at the sample of people's records we could see that practical action was taken to respond to people's needs. One person had experienced an incontinence episode. This person's daily log showed how the member of staff supported them and comforted them. They described that they made this person a, Nice cup of tea" and gave them a plate of six ginger biscuits.

The people we spoke with confirmed that staff were polite and respectful to them. One person said, "They

are all very polite and always ask me if I'm feeling ready to make a start first thing in the morning. They also ask me if I'm ready for my meal at lunchtime." Another person said, "I think they are all very respectful." During our visit to the office and when we spoke with staff, we observed that all staff consistently and without one exception, spoke about people in a respectful, kind, and thoughtful way.

All the staff we spoke with were clear about how to promote people's dignity and privacy. Staff gave us examples of how they did this. These included ensuring doors and windows were closed. Talking with the person and involving them in the personal care process. This also included giving people privacy during certain times when they supported people in this way.

The staff we spoke with also gave us examples of how they tried to promote people's independence. Involving people in their daily routines and asking them questions about how they wanted to receive support in this way. Most of the people we spoke with indicated to us that they were in fact, leading the care and support they were receiving.

Requires Improvement

Is the service responsive?

Our findings

When we visited Home Instead Luton in July 2015 we found that people received good care which was responsive to their needs. When we visited in January 2018 we found there were elements of the care people received where some improvements were required.

People told us that they were involved in the planning and monitoring of their care. One person said, "I have a care plan in my folder. A senior carer comes regularly, probably every couple of months to look at all the notes and we look at the plan to make sure it doesn't need updating. I'm always asked about any issues or concerns at the same time." Another person said, "A lady called [name of member of staff] visits us regularly and as well as checking all my [relative's] records, she looks at the care plan and we talk about my [relative's] health and if there is anything we need to change. We have the opportunity to talk to her about any concerns we have as well. She's very nice and it seems to us that she genuinely cares about getting things right."

When we visited the service's office and looked at people's care assessments, we could see that there was information which indicated that people had been involved in the planning of their care. There was personal information about people's backgrounds and their interests. People's routines were outlined and there was information about the types of drinks that people liked to have. However, from the sample of care records we looked this information was limited at times. On one person's record it stated that they liked to, "Sleep in", but it did not say until what time. One person was being supported with their meals at lunch time. It stated that they had a small appetite, but it did not say what food they liked to eat and how they liked to eat it. We found that people's assessments and plans did not fully reflect people's physical and health needs.

Despite this we could see that people were being regularly asked about their views of the care they were receiving. People were contacted after the care visits started to capture their views of the staff and the care they received. People were having face to face reviews and other contact if their needs or social situation was considered to be complex. In people's reviews people were being asked about what was not working well and what could be improved. The staff completing these reviews were recording what people said. However, these reviews were not capturing the opinions of people's regular members of staff. They also did not seek the views of relatives who were involved in people's lives, with the person's consent. Even when these people had cognitive and long term conditions which meant that they were unwell.

We looked at two people's reviews who had some complex needs. Particular issues and concerns the management team had about the support these people received were not identified at these reviews. These reviews were not identifying what had happened and what the service had done to try and resolve these issues. Or how this affected the risks which these two people faced. We spoke with the manager about this who told us what action had been taken. We saw in one of these people's records the various telephone conversations the office staff had with health and social care professionals to raise the concerns that they had and find solutions for this person. We therefore concluded that the service was responding to concerns and changes in people's needs, but this was not being captured in these people's assessments and reviews.

Out of a sample of five records we looked at people's reviews were positive. However, we noted on one person's review they had raised the issue of not receiving an up to date rota, so they know which staff would be visiting them. This issue was identified at each of their reviews. This told us that the members of staff who were completing the reviews, were not checking that the issues identified had been resolved. It also questioned how effective the audits by the management team were of these records.

When we spoke with people who used this service they gave us examples of how staff responded to their individual needs. For example one person said, "I actually asked for a much earlier call on a Sunday morning because I go to church. The office made no bother about it and my carer now comes at 7:30am each Sunday. It's important to me that I can still attend regularly." Another person said, "I chatted with the manager and discussed what times I wanted the carers to come and when I wanted a hot meal. I also don't like going to bed very early, so I didn't want an evening call until 9:30pm. They were able to arrange everything."

People told us that when staff visited them they stayed their allotted time, if they completed the required tasks they would ask if anything else was needed. People also told us that they had care visits when they wanted them. Staff were introduced to people before they started providing the care visit. Both staff and people spoke positively about this. People also said that staff were rarely late for a care visit and if they were late the office would phone. One person said, "Considering that I live almost on top of a very busy bypass, my carers have been remarkable really, and in all the months I've been with the agency, they have only been late on a couple of occasions."

Alternatively there were some people who were concerned about recent events of cancelled calls. These people did not feel that their needs were always being met. These events had also affected their confidence with the service. One person said, "The office always sent out schedules as regular as clockwork covering the next two weeks. However, over the last few months, we haven't been getting it as regularly. I think they have been struggling to find enough carers to cover all our visits. We like the reassurance of the schedule and so we know who is going to be coming into our home."

Some of the people we spoke with said if they wanted to make a complaint they would contact the manager. One person told us about a recent complaint they had made. They said, "We were given information about how to make a complaint when we started with the agency. We have talked with them about the couple of missed calls we have experienced lately. They quickly apologised, but they had no real answers for why they happened or reassurances that they wouldn't happen again."

When we looked at the number of complaints received we could see that the registered manager had responded. On these records we could see that the registered manager had apologised and responded to the issues raised. There was no information in these responses to guide people about what they could do it they disagreed with the result of the complaint. Although there was information relating to the local ombudsmen in people's 'Service User Guides.'

During our inspection we looked to see if people had 'end of life' plans or if the service had asked people if they wanted support to make these. There was no evidence to show this. We spoke with the manager who told us about one person who was palliative and how they were in regular contact with this person's health lead, for their end of life care. We looked at this person's record. They did not have an end of life plan. We spoke with the manager and asked if someone at the service had had this conversation with this person, but no one had. This is important in order to give this person the opportunity to say what support they want at the end part of their life, so staff can meet these care needs.

Requires Improvement

Is the service well-led?

Our findings

We visited Home Instead Luton in July 2015 and we found that the service was well led. At this inspection in January 2018 we found positive elements to how the service was being managed but we also found some areas were improvements were required.

When we inspected Home Instead Luton we considered the culture of the service. The registered manager told us how it was important to create a service where people's needs were met and it passed the 'Mum's test.' As outlined by the Care Quality Commission (CQC) meaning that the service was of a standard anyone would want for their own relatives. People spoke positively about the support they received from the care staff who supported them. One person said, "The carers just concentrate on me once they come through the door and they are always so cheerful. Even late on in the day, when you know they've been working for a long time." We saw that staff advocated on people's behalf to ensure they received support from health and social care professionals. All staff spoke respectfully and in a caring way about the people they supported.

Some people did raise some concerns however, about calls being cancelled and long term staff leaving. When we spoke with staff some said they felt under pressure to take on additional care visits and they did not always feel supported. However, other staff said they did feel supported. These issues related to the culture and practice of the service had not been identified until we spoke with people and the staff who supported them.

We found elements of effective quality auditing of people's daily records and MARs. Although we noted that when looking at one person's daily log out of the five we sampled it did not reflect the care that they had received. The auditor was not considering if the information recorded on this daily log reflected the actual care this person received. In this case this person was declining support with personal care for some months, but these records did not say this. The issues which the auditor did find continued to reoccur. This had not been identified by the registered manager or the management team. A course of action to resolve these issues had not been taken.

When we looked at people's care assessments, care plans, and reviews, we found some issues with these documents. People's needs were not always being captured and explored. There was not a clear guide for staff to follow in supporting people to meet their individual health, physical, and care needs. Concerns and incidents were not clearly documented in people's reviews. The manager said that people's care records were audited, but these audits had not identified these shortfalls. There was no further check to see if these audits were effective.

Staff received training and competency checks. However, we found that the records of competency checks completed on new staff to check they could work alone were not robust. Additional competency checks did not take place on a regular basis and did not evidence how a member of staff was competent. We found some short falls in staff knowledge. The training provided did not always reflect the needs that people had, who used the service. Training test scores were sometimes low. There was no real testing or auditing to see if the training delivered or competency checks were effective.

People were regularly being asked for their views of the service and complaints were investigated. However, some people and staff shared with us some concerns they had about the service which the management team were not aware of.

There was a lack of regular independent audits taking place. The franchise completed an audit in July 2017. However, they did not speak with people and their relatives and staff about their views of the service. An effective independent audit could have identified the issues we found, and gave the service the opportunity to work towards correcting these issues.

There was a registered manager in post at the service. The registered manager told us about plans for the day to day manager to apply to be the registered manager, with themselves taking a more strategic role. The registered manager and manager were aware of some of the types of events they must notify us about by law. However, the management team had identified a safeguarding concern and made a referral to the local authority, but they had not notified us about this. We explained this to the registered manager who said they would ensure this would happen in the future.

During and after our inspection we discussed our findings with the registered manager and manager of this service. The registered manager said they were committed to making these changes to improve the service. We later received an action plan identifying the issues which we found. This action plan included a course of action to resolve these issues. However, these issues had not been identified by the registered manager or provider's quality auditing systems. We had identified these issues. We considered this issue and concluded that this did in fact constitute a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our visit of the service's office we were shown documents and newspaper articles which showed that the service was actively involved in local community initiatives. These were to raise awareness and promote good practice in relation to dementia care and the social isolation that many older people experience. The registered manager had worked with a group of interested people and helped create a dementia café. Various events had taken place and were planned to take place to support people locally in this way.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12 HSCA 2008 (RA) Regulations 2014: Safe Care and Treatment The provider had not ensured that care and treatment was provided in a safe way. They had not assessed all risks to people's safety or taken appropriate actions to mitigate these risks. Regulation 12 (1) and (2) (a) (b).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (RA) Regulations 2014: Well Led. The provider did not have effective systems and processes in place to identify, monitor and improve the service. Regulation 17 (1) and (2) (a) (b) (d) (ii)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA 2008 (RA) Regulations 2014: Staffing The provider had not ensured that care and treatment was provided by staff who had the support and training to do so.

Regulation 18 (1) and (2) (a).