Network Healthcare Professionals Limited

Network Healthcare - Chipping Sodbury

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?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Overall summary

This inspection took place on 24, 25 February and 1 March 2015. This was an announced inspection. We gave the provider 24 hrs notice of our visit because the service is small and the office staff may not be available due to supporting staff or providing care. We needed to be sure that they would be in. This was the first inspection of the service since registration with the Care Quality Commission in November 2013.

Network Healthcare (Chipping Sodbury) is a domiciliary care agency that provides personal care and support to people living in their own homes. It is part of a National company that is registered with the Care Quality Commission called Network Healthcare Professionals Limited.

Summary of findings

The majority of people using the service required long term support to enable them to continue to live at home. On the day of our inspection there were 23 people using the service with 11 staff employed to deliver this care.

The registered manager had resigned in December 2014. 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 is a condition of registration that this location must have a registered manager. We were told recruitment for the post of registered manager was underway.

People had not always received a service that was delivered on time and in accordance with their care plan. The agency had increased the numbers of people they were supporting whilst experiencing a high turnover of staff. This meant that the agency was unable to provide consistent care and support during the months of November, December 2014 and early January 2015. The provider had devised an action plan and worked alongside local commissioners to minimise the risks to people. Twenty seven people had been served notice by Network Healthcare to find another care provider. Comments received from people confirmed there had been difficulties and they were not always satisfied with the care and support that was in place. However, people acknowledged this had improved in the last two months.

The majority of the people were receiving a service as planned. However, there was one package of care where there were not enough staff to provide the full seven day package of care.

People were at risk of unsafe medicine administration. This was because staff were not following the risk assessments and not recording medicines given. This meant people could not be assured they were receiving their medicines in a timely manner or as prescribed where they required support.

There was a lack of quality monitoring being completed to enable the provider to make a judgement on how effective and responsive the service was. This included making any improvements to people's care and support packages. Complaints were not recorded centrally so could not be analysed for any themes or trends. Some complaints had not been investigated in a timely manner with feedback given to people on how their concerns had been responded to. Some people and their relatives were not satisfied their concerns had been listened to.

People commented positively about the care staff that were supporting them. They told us they were treated kindly, with respect and the staff were caring. People told us the staff had the skills and knowledge to support them effectively. People confirmed they had a plan of care that they had agreed. Care plans clearly described the support needs of people and these were kept under review.

People told us they felt safe. Staff knew what to do if they suspected that an allegation of abuse was taking place. Staff had been through a thorough recruitment process ensuring they were suitable to work with vulnerable adults and children. New staff shadowed more experienced staff until they were confident to work on their own. Some people told us that when new staff started they had to explain to them how they wanted to be supported.

Staff confirmed they received regular training and were supported in their roles. However, it was acknowledged that this was not always the case. They said there had been a lot of pressure put on them during November and December 2014 to ensure people received the care and support they required. Staff stated they now have regular people they support enabling them to build relationships with.

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

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

We found some areas of the service were not safe.

People's medicines were not managed safely. There were some shortfalls in staffing which meant one person was not receiving the care package that had been agreed.

People felt safe and risks to people's health and wellbeing were appropriately managed.

Staff knew how to recognise and respond to abuse.

There were safe recruitment and selection procedures in place.

Is the service effective?

Requires Improvement

We found some areas of the service was not effective.

Staff were aware of their legal responsibilities in respect of gaining consent and involving people in their care. However, there was a lack of information about what responsibilities people's representative had in respect of their role as power of attorney.

People were supported with their meals where required. People's health needs were monitored and advice taken from other professionals where required.

Staff received appropriate training enabling them to fulfil their roles. Specialist training was in place such as supporting children and specific training around people's healthcare needs.

Is the service caring?

Good

The service was caring.

People felt respected and well cared for. Information about people was person centred and detailed how they liked to be supported. This included any cultural needs.

People and their relatives were involved in making decisions about their care and treatment.

Is the service responsive?

Requires Improvement

The service was not consistently responsive to people's needs.

People's concerns were not always responded to promptly. Records were not returned to the office in a timely manner and this meant there was a risk of peoples changing needs not being met.

Most people felt that the service responded and delivered the support they required. Care documentation was in place to guide staff and these had been kept under review.

Summary of findings

Is the service well-led?

The service was not well led.

There was no registered manager and there was a lack of senior management presence to guide and support the office staff in the office.

There was a lack of robust systems to check that people were receiving a quality service enabling them to make improvements. Where people had been asked their views these had not been acted upon.

Requires Improvement

Network Healthcare - Chipping Sodbury

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.

Before the inspection we reviewed the information we held about the service. This included information the provider had sent us in their Provider Information Return (PIR). The PIR asks the provider for some key information about the service; what it does well and any improvements they plan to make. We reviewed notifications the provider had sent us since being registered with the Care Quality Commission. A notification is information about important events which the service is required to send us by law. We also looked at information received through the CQC share your knowledge portal about the service and other information of concern raised by professionals and care workers.

We sent out surveys to people who use the service and relatives. Sixteen people using the service and 4 relatives responded.

The inspection was carried out by one adult social care inspector. Time was spent in the office looking at records relating to the running of the business and those relating to care. We looked at care records for eight people and four staff member's training and recruitment records. We also looked at the computer system used to book and record visits to people. We visited one person who received care from Network Healthcare and spoke to a further seven people on the telephone. In addition we spoke to a commissioner from South Gloucestershire Council and received feedback from a social worker.

We spoke with three members of staff that worked in the office at Chipping Sodbury, the regional manager and a further two staff on the telephone. This was to seek their views on the care and support they were providing and the support they received.

After the inspection we requested further information about policies and procedures to enable us to make a judgement about the quality of the service. This included information about what checks on quality the provider was completing at the Chipping Sodbury office.

Requires Improvement

Is the service safe?

Our findings

People told us they now felt safe when receiving a care service. Everyone we spoke with told us that this had not been the case in December 2014 where visits were cancelled, missed or they were unsure who would be supporting them. People told us they had been contacted during this time with reassurances that this would improve. Everyone that responded in the survey told us they felt safe from harm of being abuse from the staff.

Some people required support with their medicines. There was information recorded on a survey completed by a relative in the office of concerns where staff had not given medicines at the correct time. For this person it meant they were at risk of a deterioration of their medical condition. Another person's care records stated that the relatives responsible for given the medicines. However, from the daily reports of the visits staff had written 'medicines given'. We spoke with a member of staff who confirmed they were given the medicines. Staff were not following the care plan and medicine risk assessment.

Where people were assisted with their medicines staff maintained a record of what was given. An audit had been completed on the medication administration records (MAR) in January 2015. Some of the records that had been checked were dated August 2014. This meant the agency could not respond to concerns with medicines promptly. There were gaps in signatures on most of the medicine administration records. This meant that the agency could not be assured people were receiving their medicines as prescribed and people were safe. Staff were not consistently following the medicines policy in the way they were recording medicines given as some staff had recorded this in the daily record.

These were breaches of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 management of medicines. You can see what action we told the provider to take at the back of this report.

Staff told us that since September 2014 the agency had steadily increased the numbers of people they were supporting. During this time staff told us they were being constantly asked to cover additional people and work in areas they were not familiar with. The provider told us in December 2014, 15 care staff, two office staff and the registered manager had left the service. This meant there was insufficient staff to support people safely and ensure all visits were covered. The provider shared this information with South Gloucestershire Council and Bristol City Council who commission the service and the Care Quality Commission as the agency was in crisis. An action plan was developed which meant that 27 people were given notice to find alternative care providers. In addition another local Network Healthcare office provided additional staff to enable care to be delivered. However, it was acknowledged by the provider and the staff that this might not have been at the normal times or for the full duration, with some visits being cancelled. Staff told us they had prioritised all calls to people in relation to the level of risk for example, where meals or medication were critical or where there was no family member to provide the support.

Assurances were provided by the regional manager and staff in the office that they had sufficient staff to support the people that were receiving a service at the time of the inspection. They told us since the beginning of January 2015 no calls had been missed or cancelled and care was being delivered in accordance with people's needs. On going recruitment was now taking place to ensure that there were additional staff to cover any further shortfalls. Staff confirmed that since January 2015 their work load was more manageable, with suitable travel time between each visit.

Most people told us that their service had improved over the last two months with visits taking place in accordance with their care plan. However, one person was not receiving a regular service from the agency. This was because they were unable to allocate staff to support this particular person at the weekends and one evening per week. A social worker confirmed the family were not receiving a seven day service and they had raised concerns with them. Whilst the family had been kept informed that the agency was unable to provide a service due to sufficient and appropriately skilled staff this was not acceptable. The regional manager told us this would be reviewed, they were considering sharing the care package with Network Healthcare Bristol office who had a dedicated team to support people with a learning disability.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 staffing. You can see what action we told the provider to take at the back of this report.

Requires Improvement

Is the service safe?

We asked to look at the assessment framework for prioritising visits for the 23 people that were being supported at the time of the inspection. Everyone was assessed as being at high risk. Although some of the calls were for social contact or they lived with a family member therefore this may be categorised lower. This meant the service would be unable to prioritise work in the event of a further crisis or where extreme weather conditions affected the level of support that could be given. Where people were placed by the local authority they had risk assessed the visits for people as critical, substantial and low to medium risk. This had not been captured in the care plan devised by Network Healthcare or the computerised planning tool for visits.

Each person had a care file which contained information to keep them and the staff safe. Environmental risk assessments had been completed as part of the initial assessment process. These had been kept under review in the majority of cases. However, it was noted on one person's environmental risk assessment that a situation would improve when they moved to a new property and had access to a walk in shower. Staff confirmed this had now been addressed but the environmental risk assessment had not been reviewed and updated. The address of the person had not been recorded on the environmental risk assessment so it was difficult to clarify if this was for the new or the previous property of residence. Staff told us this person had a review arranged and this would be addressed.

The environmental risk assessment included an alternative contact in the event of an emergency. For example, if there was no one at home when the staff visited, they were able to contact a neighbour or a relative. Staff were aware of the procedure to follow if a person was not available during a planned visit. This included making contact with the office and contact with the police if they were concerned about the welfare of the person.

Each person had personalised risk assessments. This could be risks due to choking, a medical condition such as epilepsy and the delivery of personal care. Where moving and handling equipment was used this was clearly described including the specific equipment. Staff confirmed they received regular training in safe moving and handling procedures. This was updated where the person's needs had changed and new equipment was in place. A member of staff confirmed they had received specific training on moving and handling for one person. They told us the relative was meant to assist but often was not available. This had been brought to the attention of the care co-ordinator who was arranging a joint visit to ensure the systems in place were safe.

Financial procedures were in place and followed by staff to safeguard people's monies. A person told us "the staff are very good they always make sure there is a receipt and record in a book when they complete any shopping for me".

Staff told us they had completed training in safeguarding adults and were aware of what constituted abuse and who they must report this to. Staff confirmed they would report concerns to the office staff and these would be responded to promptly. The contact details for the local safeguarding team were incorrect in the agencies safeguarding policy. As it made reference to Gloucestershire City Council. However, all of the people the agency supported lived in either South Gloucestershire or Bristol City Council's boundaries. The regional manager told us this would be addressed and that the policy in place was from their Dursley office and had not been updated to include the correct contact details.

Where staff worked with children and young people they had attended training on safeguarding children with South Gloucestershire Council. Staff were aware how they could raise concerns using the service's whistle blowing policy stating they would either speak with the regional manager or the director.

The provider followed safe recruitment practices. We looked at the recruitment files for four members of staff and found suitable checks had been completed. All members of staff had at least two satisfactory references and had received Disclosure and Barring (DBS) checks. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services. A member of staff who had responsibility for employing staff was able to tell us of the agencies responsibility to ensure all recruitment documentation was in place before staff worked with people.

Requires Improvement

Is the service effective?

Our findings

People were generally satisfied with the care staff confirming they usually had the skills and knowledge to support them. However, everyone acknowledged that this may not be the case when a new member of staff visits for the first time. Four of the eight people told us that new staff often need to ask more questions on how they like to be supported. Four people told us that calls on the day before the inspection were late as the member of staff was new and did not know the area. They told us the agency had not contacted them to let them know about the late visit or the reason although the member of staff did apologise stating it was due to heavy traffic.

Surveys received indicated that 69% of people had familiar care staff supporting them. However, only 27% stated the care staff arrived on time. The surveys had been completed in December 2014 when there was a high turnover of staff. People told us this had improved and they were now having regular staff supporting them.

Staff were aware of the Mental Capacity Act 2005 (MCA) and how this impacted on the delivery of care and the importance of involving people in decisions about their care. This is important legislation which establishes people's right to take decisions over their own lives whenever possible and to be included in such decisions at all times. Staff were able to describe how the person's best interests were safeguarded and how they would support people, wherever possible, to make choices about care for themselves.

Each person had their mental capacity assessed in relation to making day to day decisions. We saw that some people had given another person responsibility to make decisions through the appointment of a power of attorney. However, there was no clear information on what responsibilities the person had. It was not clear whether, this was in respect of finances or making important decisions about care and support. This meant there was a risk the appropriate person would not be consulted on important decisions.

People's medical histories were recorded as part of the assessment and care plan process. This included other professionals involved in the care and support for the person such as their named GP and district nursing team. Staff told us they reported any health concerns to the main office, who would then make contact with a relative, GP or discuss with the individual or family member.

The office staff described how they matched people with staff. People were asked about their preferences in relation to the gender of the staff and their interests. Staff were allocated to individual people to enable them to build relationships. These were kept under review during care reviews to ensure that people were happy with the staff that were supporting them. People confirmed where they were unhappy then changes were made to the staffing arrangements.

People told us staff support them by providing suitable food and drink for them where required. One person said "the staff are lovely, we do it together, they assist where I am unable to do things for myself but I do still enjoy preparing my own meals". Another person told us "they always ask me what I would like in my sandwich or what I would like for lunch and ensure I have drinks". People's likes and dislikes in respect of food and any allergies were recorded in the plan of care. Staff had received training on food hygiene and this was updated annually.

Staff had effective induction, supervision, appraisal and training. All new staff received an induction programme that included practical moving and handling, cardiopulmonary resuscitation (CPR), Mental Capacity Act 2005, first aid, medicines, dementia, safeguarding, infection control, and health and safety training. Annual updates were completed in these core subjects. New staff shadowed more experienced staff until they were confident in their role. Staff confirmed they had attended training but told us they were not paid for attendance which made it difficult sometimes if it conflicted with their paid work.

In addition staff received specific needs based training for the people they were supporting. Some staff had received training in epilepsy, supporting people with a learning disability, child safeguarding and oxygen therapy. This training had been delivered by the local community children's learning disability team.

Good

Is the service caring?

Our findings

People spoke positively about their main care staff that supported them. One person said "I have a about six staff that support me, seven days a week, three visits a day. They are all lovely". Another person told us "you cannot fault the girls they are all very kind and friendly it is a shame the office staff let them down". This person told us that in the past, a member of the office staff was often rude when they phoned, but they have now left and it was getting better.

94% of people receiving a service told us in surveys that they received care from staff that were caring and kind. 100% of relative feedback through the survey indicated that people were treated in a respectful and dignified manner and the staff were caring and kind.

People described a service where the staff were caring towards them. One person said "I have recently asked someone to be a bit more gentle as I was in pain, but once I pointed it out there has been an improvement, It was not her fault she just did not know". People told us it was much easier when the care staff were regular as they knew how they liked to be supported. Some people said when new staff start you have to spend time telling the staff what you want. One person said "it gets better when you get to know them and they get to know you, everyone has to start somewhere".

People confirmed they were treated with dignity and respect. A person told us "they never talk down to me, they treat me very well and always ask me how I want to be supported, I would not have it any other way". People told us it was important to them they got on well with the staff. Where people had raised concerns about a member of staff they felt the office staff had responded appropriately and the person was not sent again.

People confirmed that care was delivered in the privacy of their home. Staff confirmed that when relatives were present care was delivered behind a closed door or in another room to ensure the privacy of the person. Staff told us that where key safes were used they always alerted the person before entering the property by ringing the doorbell or shouting out to alert them they had arrived and asking their permission to enter their home.

People confirmed they were encouraged to be independent where they were able. This included assisting with meal preparation. A person told us "we do it together, I still enjoy helping in the kitchen, it is a joint effort". Another person said "I can do most things for myself, but need assistance with putting my socks and shoes on; they allow me to do what I can for myself". All surveys responses from people and their relatives indicated that staff encouraged people to be as independent as possible.

People's cultural needs were clearly described in the care plan including any specific requirements that were required. Staff confirmed they were aware of people's cultural needs before they started working with them such as a special diet on the grounds of religion.

People told us the staff always explained to them what they were doing and asked them if they were happy before they started. Staff confirmed that they would always check with the person or the family in respect of a child if they were happy for the care to be delivered. One person told us "the girls always ask is there anything else they can do, they often put my dustbins out for me".

Requires Improvement

Is the service responsive?

Our findings

People told us they were not always kept informed about their visits, for example the times and the name of the staff. People told us they felt this was important so they knew in advance who was calling on them. One person told us "I often get the rota too late, I like to know who is coming especially if I have a concern about a certain member of staff, I can then contact the office to let them know I am not happy". They did tell us they did not have any concerns about their present care staff. We spoke with the office staff about sending information to people about the rotas and staff supporting them. We were told these had only recently been restarted and these were now being sent on a Thursday for the following week.

People told us there had been improvements in the service over the last couple of months. Since January 2015, the care staff were more reliable and always stay the full amount of time. Where services were commissioned by either Bristol City or South Gloucestershire Council, staff were expected to telephone on arrival and when they left. This enabled the office staff to monitor visits to ensure they had taken place and for the correct duration. Where a call was half an hour late an alert would be sent to the office to enable them to check with the person if had received care and follow up on any late or missed visits with the staff member. A commissioner from South Gloucestershire Council confirmed there had been an improvement on the service being provided and there had been no missed calls between January to February 2015. Some people told us they did not always receive a call from the office about a late visit.

One person raised concerns about the timings of their visits. They told us "staff come anytime between 9:20 and 10:00 to assist with my morning wash but I would like this earlier as I seem to be sitting and waiting for them". The office staff confirmed they occasionally received calls about the timings of visits but this has to be managed taking into consideration priority visits. For example people who require medicines or assistance with meals. However, they told us they do try to listen and arrange visits to suit people's individual needs. They told us if a person had a medical appointment and required an earlier or later visit this was usually accommodated.

People were assessed prior to a package of care starting. A care quality assessor would meet with the person prior to arranging care. This was to establish what care and support the person required, enabling them to devise a care plan. In addition information would be sought from the person's social worker and relatives.

People confirmed they had a care plan in their home and staff recorded information about each visit. Each person had a care plan detailing their support needs, the times of the visits and any risks relating to their care. In addition there was contact information for the person's next of kin and or neighbours in the event of an emergency. People's care needs were reviewed annually or as needs changed.

Daily records and medicine records were not being returned to the office promptly. This meant the office staff were unable to review information to ensure it reflected the care plan enabling to a person's changing needs. For example had the daily records been returned promptly for one person it would have been noted that staff were medicines rather than a family member. The assistant manager told us the care quality assessor would now collect all daily records and medicine administration records on a monthly basis for all people using a service. These would then be reviewed monthly by the office staff for any discrepancies so that care plans could be updated to ensure they were current and staff were responsive to people's care needs.

Most people told us they knew how to raise a concern and would make contact with the office if they had any concerns. People had information about how to raise a concern either directly with Network Healthcare or with the local placing authority. A copy of the complaints procedure was sent to each person as part of a welcome pack when they first started with the agency. 94% of the people who responded in the survey stated they knew how to complain, with 69% agreeing the agency responded appropriately to their complaints. However, only 2 out of the 4 relatives stated they felt the agency had responded to their concerns appropriately.

There were four complaints recorded between January 2014 and March 2014 in the complaint file. There were no other complaints recorded since March 2014. These had been investigated and a response sent to the complainant. A member of the office staff had found a further three complaints that had not been filed in the complaint file. These had been received in November 2014, December

Requires Improvement

Is the service responsive?

2014 and February 2015. These related to concerns about a member of staff, missed visits and medicines not being given to a person. There was evidence that these had been investigated.

We also saw in surveys a number of concerns that had been raised about the delivery of care. This included medicines not being given at the appropriate time, staff wearing inappropriate footwear, staff not carrying their identification badge and missed visits. These had not been investigated or recorded in the complaints file. In addition, we saw that some concerns had been recorded on the electronic system. For example one person had phoned to say they were not happy they were not receiving a service at the weekends. There was no evidence this was investigated or followed up. This meant the people could not be confident their concerns were listened to or investigated.

This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 complaints. You can see what action we told the provider to take at the back of this report.

Requires Improvement

Is the service well-led?

Our findings

There was no registered manager who was responsible for this office. The registered manager resigned in December 2014 and left without completing their notice period. In addition a care co-ordinator and another member of office staff left. In response the agency employed an assistant manager who commenced in post on the 15 December 2014. They were in charge on the day of our inspection. The regional manager told us recruitment had commenced for a registered manager. During November and December 2014, 15 care staff left.

The agency had increased the number of care packages they were providing over a period of three months leading up to Christmas. During this time 15 care staff had left. As a consequence of the increase in the number of care packages and the staff leaving, the agency went into crisis and was unable to fulfil their obligation in providing care and support to people. Visits were not taking place at the correct times, cancelled or family members were asked to provide the additional support. The provider alerted the local safeguarding and commissioning teams and an action plan was developed to reduce some of the risks to people. The agency served notice on 17 December 2014 to 27 people advising them they would need to find an alternative provider.

The regional manager told us the provider was only alerted to the crisis in late November 2014, they took immediate steps and asked staff from another local Network Healthcare office to assist with staffing and management support. The regional manager told us they were aware there was a business reputational risk and work would have to undertaken both with commissioners and the general public in regaining confidence in the company.

We asked to see records of any provider visits or any other management visits completed on behalf of the provider. The assistant manager told us another registered manager and the regional manager had visited twice since they had taken up post. The staff told us there had been little senior management support or direction. However, they could contact the provider or the regional manager for telephone advice. The lack of support given to the assistant during this time was acknowledged by the regional manager who was responsible for four other services and based in Cornwall. There were no formal checks completed on behalf of the provider on the various systems to monitor how effective the branch was operating.

Network Healthcare Chipping Sodbury is part of a large organisation providing care and support to people in their own homes. The regional manager told us that each branch operates independently and there were no audits completed on quality by the provider or their representative. However, in response to the concerns raised at this branch this was now being introduced to all registered offices. An audit was going to be completed by an independent assessor at each branch on an annual basis with self audits completed by the registered manager taking place throughout the year. In addition, each month, branch managers would be expected to submit information about the staffing arrangements including, staff leaving and recruitment, how many care hours they were providing, information about missed calls, complaints, safeguarding alerts raised, incidents and accidents and staff training on a monthly basis. The regional manager told us this would enable senior management to monitor the service more frequently and identify if there were any concerns or shortfalls.

Although this service had been in crisis no audit had been completed to ascertain where the problems were. There were no exit interviews for staff leaving. Comments were that this was due to poor management however, some staff told us the manager had been put under considerable pressure by senior management to expand the business as it was not viable. This was done without ensuring sufficient staff were in place to pick up the additional work. The growth rate over three months had doubled the numbers of people they were supporting without sufficient recruitment of staff taking into consideration staff leaving.

We were shown an audit file containing a variety of checks that had been completed on staff training, medicine administration and daily records. No formal audits had taken place between September 2014 and January 2015. The assistant manager told us they had recently checked medicine administration records and daily records for any concerns or gaps. We were shown the records of these checks. Records were not being returned to the office promptly some of the records were dated August 2014. This meant the manager was unable to effectively monitor the quality of the care provided.

Requires Improvement

Is the service well-led?

We looked at the provider's quality assurance policy. This lacked any detail other than sending out annual surveys to people who used the service. It stated that quality was everyone's responsibility but it failed to provide guidance on what was expected of them in relation to what formal checks on the quality were required.

Due to complaints from people not being recorded in one central record this meant it was difficult for the manager or the staff to review these for any themes or trends. The assistant manager told us they had not received any training on responding to complaints and had received no direction from the senior management team. We were shown surveys dated from September 2014 there was no evidence these had been analysed for any themes or trends to improve the quality of the service. There had been some concerns raised people but there was no evidence these had been addressed.

The lack of formal provider checks, the inconsistency in the checks on records and the lack of analysis in relation to complaints and the surveys meant systems were not in place to monitor the quality of the service.

These were breaches of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 assessing and monitoring the quality of the service. You can see what action we told the provider to take at the back of this report.

The assistant manager told us they had previous experience working for Network Healthcare at another branch in an administrative role. In addition to the assistant manager, there was a care co-ordinator who started in January 2015 and a care quality assessor who had worked for Network Healthcare Professionals Limited for three years. They had worked at this branch for the last twelve months. The care co-ordinator's role was to plan the care to be delivered, matching people to staff and checking that the visits had been completed. The care quality assessor's role was to review the care delivery, ensure care plans were up to date and supervise the staff. We spent time with all three members of staff who were able to demonstrate how they worked with the computerised staff planning tool and recorded information about people.

Regular staff supervisions were taking place where the care quality assessor met with the member of staff to discuss their role and any training required. In addition regular spot checks were completed where by the member of staff's competence was checked to ensure they were following the care plan and the procedures of the organisation. This included checking if the staff had their identification badge and was wearing suitable clothing and following infection control guidance.

People were aware of the names of the staff in the office and confirmed they had either met them in person or spoke with them on the telephone. They told us communication with the office had improved over the last two months and felt confident that if they contacted the office they would have a response to their concerns or questions. We heard staff answering telephone calls in a professional and friendly manner. One person told us "X is really lovely; she has supported me recently with my care, very friendly and professional both in person and on the telephone".

Staff told us that communication had improved over the last two months. One member of staff told us "I am glad I stayed working for the agency, it was tough during November and December 2014. You were constantly being telephoned and bullied to cover visits, it was not fair to the staff or the people as they did not have familiar staff supporting them, no one really knew what was happening". Staff confirmed a senior member of staff had contacted them during this time promising them it would get better. One member of staff said "I am glad I stuck it out, it so much better now, I know what I am doing now and have regular people to support". One of the people we spoke with said "I was asked if I wanted to stay with the agency, I am glad I did, I like Network Healthcare I have been with them for about three years". They told us they had previously received care from an office in Dursley but this had transferred to the Chipping Sodbury office.

The provider information return was submitted to us on the 28 November 2014. There was no information regarding the concerns in the agency in relation to the staffing or the capacity issues. They had identified areas for improvement including medicine training being sourced from an external provider and on going recruitment of staff being a focus for the next twelve months. There was no evidence that the medicines training had been arranged for staff. The data supplied and evidence from the inspection was contradictory as it was reported there had only been one complaint in the PIR when there had been seven in the last twelve months. They also reported there was no one who

Requires Improvement

Is the service well-led?

had a power of attorney but in fact we saw there was a person. This did not show an understanding of the service being provided from the Chipping Sodbury Office, the shortfalls or what improvements were required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 13 HSCA 2008 (Regulated Activities) Regulations 2010 Management of medicines People who use services were not protected against the risks associated with unsafe use and management of medicines. Regulation 13.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints People and others could not be confident their complaints were handled and responded to appropriately. Regulation 19 (1) (2) (a) (b) (c) (d)

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service provision The registered person has failed to protect people and others against the risks of inappropriate or unsafe care and treatment by means of an effective operation of systems to regular assess, monitor the quality of the service. Regulation 10 (1) (a) (b), (2) (a) (b) (i) (ii) (iii) (v) (v) (3) (c) (i) (ii) (e) (3)

Regulated activity	Regulation
Personal care	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person had failed to ensure there were sufficient numbers of suitable qualified, skilled and experienced person employed for the purpose of carrying on the regulated activity. Regulation 22.