Age UK Northumberland

Age UK - Northumberland

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**

Summary of findings

Overall summary

Age UK Northumberland provides personal care and support to people in their own homes. This inspection took place on 25 November, 5 December and 16 December 2016 and was announced. We gave the provider 48 hours' notice to ensure staff were available to support us during the inspection and that we had the necessary access to records. The service was providing care to 717 people provided by 219 staff.

A registered manager had recently been appointed and had completed the registration process with CQC just prior to our visit. After we had completed our inspection we found the registered manager had left the service and there were plans to appoint a replacement. 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.

People and their relatives told us they were happy with the service provided and that staff were caring and generally reliable. They described an overall impression that the reliability and efficiency of the service had improved of late but still expressed some concerns about some aspects of the quality of the management of the service. We observed staff to be caring and attentive during our visit.

A number of audits and quality checks were carried out but we found that records did not always reflect the accurate situation in people's homes and there were gaps in records related to recruitment, complaints and best interests decision making.

Staff received regular training, but the method of recording training was difficult to analyse to assure us of numbers of staff completing specific training. The organisational development director told us this was something they planned to change during a systems overhaul in the new year. Training considered to be mandatory by the provider was carried out on an annual basis. Staff confirmed they received regular training and one to one supervision with their care coordinators . Managers carried out spot checks of the service, where they visited staff to ensure they were carrying out their duties effectively. Not all staff had experienced these but knew they took place.

Records of competency checks and some training such as catheter care were not always recorded although we were told these had been carried out. A high number of staff had requested training in supporting people with dementia or mental health needs and we were told by the organisational development manager that this was planned for the new year. We judged that some priority should be given to providing training for staff providing care to people with complex mental health or dementia related needs.

Risk assessments were carried out in the homes of people cared for, which identified general environmental risks, and specific risks to people. These were up to date but we found some examples of where changes had occurred and this information had not always been passed back to office managers or records updated.

People told us they felt safe in the care of Age UK and staff demonstrated a good understanding of issues related to the safeguarding of vulnerable adults.

Procedures for the safe management of medicines were in place and followed by staff. We visited four people at home and found that staff were aware of the procedures to follow. Staff had received training around specific conditions and equipment related to a medical need, to enable them to care for people safely. This training was carried out by visiting professionals whenever there was a need and was bespoke to the needs of the person using the service.

A recruitment drive was ongoing. The service was working towards a reduction in the number of people they cared for, as they had to be supported by other organisations on a sub contracted basis. We were informed there had been a significant reduction in this. There had been difficulties with staff working flexibly to meet the needs of the service, due to a majority of staff being employed on zero hours contracts and therefore able to turn down work at short notice. This was in the process of changing, and staff consultations were taking place to change contracts which would mean greater reliability and to enhance the working experience of staff. People told us that staff had time to attend to their care needs.

Recruitment checks were carried out to ensure staff were suitable to work with vulnerable people including checks by the Disclosure and Barring Service (DBS). Interviews were carried out and there was a scoring process to follow to help with recruitment decisions. We found that scoring and interview decision records were not always completed or the decisions to appoint people where concerns had been identified were not recorded or explained.

Training in the Mental Capacity Act 2005 (MCA) had been carried out. We were told no one was subject to any restrictions in their daily lives but we found this was the case for one person. Systems in the service had not identified and recorded this. We have made a recommendation about this.

People were supported with eating and drinking, and nutritional assessments were carried out. Appropriate advice was sought where people were deemed to be at risk of malnutrition or dehydration, and staff were trained to deliver nutrition via specialist equipment when required, such as via Percutaneous Endoscopic Gastrostomy (PEG).

People's needs were responded to by staff. We read call logs which demonstrated that staff had picked up on health problems and taken appropriate action or sought advice. Care plans had detailed outcomes and clear expectations of staff regarding the support people needed during their visit. Social needs of people were considered during care planning.

People and their relatives told us that their complaints had been responded to, and that when they had cause to complain, the service had improved. We read complaints records and found these varied in detail and format. Outcomes to complaints were not always recorded so it was not always clear what action had been taken. Complaints were not recorded in a way which supported audit and review of outcomes.

The newly registered manager had worked in the service for a number of years. New posts had been introduced to support managers and coordinators and these were called staff mentors. They were a source of support and advice for staff. This also provided greater opportunities for staff career progression. A number of people told us that the quality of support they received from 'managers' (including coordinators) varied depending on who responded to their issues. There were also concerns raised about the length of time that it could take to get through to the office by telephone despite the extended office hours.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to staff training and good governance. You can see what action we told the provider to take at the back of the full version of the report.

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

Not all aspects of the service were safe.

Recruitment records did not always demonstrate best practice had been followed in the recruitment of staff.

People and their relatives told us they felt safe. Staff had received training in the safeguarding of vulnerable adults and knew what to do in the event of concerns.

Medicines were managed safely and risks in people's homes and their individual care needs and been assessed.

Is the service effective?

Requires Improvement

Not all aspects of the service were effective.

Capacity assessments and best interests' decision-making records did not reflect the care provided to people. This included restrictive practices.

Staff did not always receive training in a timely manner and records were difficult to analyse to ensure compliance.

People were supported with eating and drinking, nutritional concerns were reported and specialist advice was sought.

Is the service caring?

Good

Staff were caring.

Feedback about the standard of care provided was very positive. There was a perception that there had been an improvement in the continuity of care.

Staff upheld the privacy and dignity of people, and supported people in the way they preferred. We observed that staff treated people with kindness and respect.

An equality and diversity policy was in place and people had access to a range of services provide by Age UK nationally, including advocacy.

Training in end of life care was in the process of being updated and improved.

Is the service responsive?

Requires Improvement

Not all aspects of the service were responsive.

Complaints were addressed within the correct timescales but records did not always contain sufficient detail to show appropriate action had been taken.

People told us their needs were responded to. Staff showed an awareness of how to adapt their approach to meet the needs of individuals. People told us their regular care workers responded to them in the way they preferred.

There were some gaps in care records but they were detailed and individualised.

Is the service well-led?

Requires Improvement

Not all aspects of the service were well-led.

A number of records had not been satisfactorily maintained, and systems to audit the quality and safety of the service had not picked up all of the shortfalls we identified during the inspection.

Some aspects of the service had improved, including greater reliability. There were a number of concerns raised about the quality of the response to calls to the office.

There were plans in place to improve the quality of the records and data available for quality monitoring purposes.

Age UK - Northumberland

Detailed findings

Background to this inspection

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

This inspection took place on 25 November, 5 December and 16 December 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed support to arrange visits to people who used the service, to access records, and to speak with the relevant staff.

The inspection team consisted of two inspectors 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. Our expert had experience of care for older people.

On this occasion we did not request a provider information return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.
We also reviewed information we held about the service including statutory notifications. Notifications are made by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. They are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of. We spoke with the local authority safeguarding adults and commissioning teams. We took the information they provided into account when planning our inspection.

We spoke with six people who used the service and seven relatives by telephone. We visited four people at home where were also spoke with two relatives. We spoke with eight staff including, the registered manager, a care coordinator, the organisational development manager, and five care workers.

We checked nine care plans and ten staff recruitment and training files. We also examined a variety of records related to the quality and safety of the service.

Requires Improvement

Is the service safe?

Our findings

People and their relatives told us they felt safe with the care workers who visited them. Comments included, "I trust them implicitly so yes I am safe with them", "Yes I feel very safe with them. I am very lucky to have them." "(Name of relative) is definitely safe with them. They are very professional", and, "My relative is definitely safe with them, they are like friends now. Plus I am here so I hear and see everything."

We reviewed ten staff recruitment files and found that checks were carried out. These included references and Disclosure and Barring Service (DBS) checks. The DBS checks whether staff are suitable to work with vulnerable people, which helps employers to make safer recruitment decisions to help protect people from abuse. Interview notes were recorded, and there was a scoring system in place which helped to support the decision making process, For example, an applicant with a particularly low score might not be suitable for appointment. We found that these scores had not always been completed, and where a low score had been attained in addition to other information which could give cause for concern, the appointment had still gone ahead. There was no record of any form of risk assessment or rationale to explain this decision although we were told additional information had been taken into account, but records did not adequately reflect this.

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

We spoke with the organisational development director and the registered manager about staffing. They told us that they were working with staff to change the way they worked by offering guaranteed hours and moving away from zero hours contracts. They hoped this would increase the flexibility and reliability of staff and prevent care workers from handing back scheduled visits at short notice. New terms and conditions were in the process of being agreed with staff and consultation was ongoing at the time of the inspection. A recruitment drive to increase the number of care workers was also ongoing.

Most people and their relatives told us that staff had time to care. One person said, "They always have time to listen to me if I need to talk." Another person said, "The carers are good they will talk to me if I need a chat." One relative told us, "They (line managers or care coordinators) give them too many calls and have unrealistic expectations of them." We spoke with care workers who told us they were happy with their workload. One care worker told us that things could be a bit disorganised, if enough travel time had not been allocated but that generally things were okay.

Safeguarding and whistleblowing policies and procedures were in place. All staff had received training in the safeguarding of vulnerable adults and when we spoke with them they were able to give examples of what might constitute abuse or neglect and were aware of how to report concerns. Staff were aware of the potential for financial abuse and said they kept careful records of transactions. A cash handling procedure was in place. Staff were also aware that they were unable to accept gifts and told us they would politely decline and report to the office if anyone had tried to give them anything. Safeguarding issues were under investigation at the time of the inspection and we will report on the outcome of these if necessary once

complete.

We reviewed the provider's medicine policy. A procedure was in place for the safe administration of medicines. Care workers described how medicines were administered in line with the policy. A medicine profile in people's homes listed the medicines they were prescribed including the dosage and route. Care workers recorded when medicines had been administered from a dosette box (a pre-filled container with compartments containing medicines to be given at specific times of the day) or from a pharmacy labelled container. All staff had received training in the safe administration of medicines, and regular competency checks were carried out with care workers. We asked people about their medicines and they told us they had no concerns about their medicines. Relatives we spoke with confirmed this.

Environmental risks and individual risks to people who used the service had been assessed. Risks to care workers had also been assessed, for example if there was a pet in the property they needed to be aware of. Care workers told us that they were aware of the need to report any changes or increases in risks back to the office. One care worker told us they had noticed a deterioration in a person's ability to chew and swallow and were going to inform their line manager or care coordinator to ensure they received a reassessment and specialist support if necessary. Individual risks to people related to their behaviour or physical and mental health had also been assessed. We saw that a care worker had suggested a fire retardant rug for a person who smoked to try and mitigate risks associated with their smoking.

A record of accidents and incidents was maintained and staff were aware of the types of issues that needed to be reported. One care worker told us, "We report all accidents and incidents to planners (line manager or care coordinator), and we also complete a sheet and put an entry in daily records. The person's next of kin is always informed." Call logs made in the office showed that care workers had reported these and care files contained information about accidents and incidents and the action taken.

Procedures to protect people from the risk of the spread of infection were followed including the use of personal protective equipment such as gloves and aprons, and staff wore uniforms. We observed staff following these procedures. It was important that they were followed as care workers moved from home to home.

Requires Improvement

Is the service effective?

Our findings

People and their relatives told us they thought the service provided to them was effective. One person said, "They are very competent we are pleased with them." Another person said, "I would say they are well trained, they are very good for me."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. We spoke with the registered manager and other supervisory staff who told us that there were no restrictive practices taking place and that no one was subject to any applied via the court of protection. The Court of Protection makes decisions on financial or welfare matters for people who can't make decisions themselves at that time because they lack the capacity to do so. We asked whether there were any medicines given covertly. Covert administration of medicines involves disguising it in food or drink where it is deemed in the person's best interests to be given without their knowledge due to serious risks to their health or wellbeing if it was not taken. The registered manager and supervisors told us there were no covert medicines being administered but they recognised the potential for this so were going to update their medicines policy to include this.

When we visited a person at home we found that restrictions had been placed on them in their best interests and that covert medicine was in fact being administered in line with instructions from a GP. The needs of this person had changed since the last review of their care plan and care was being provided in a way which was designed to maintain their safety. However, this information had not been reported back to the registered manager or other supervisors, and best interests' decisions had not been documented. We were also told by care workers they had been instructed by a relative with power of attorney to keep the external doors of the property locked at all times to prevent the person from leaving the house unsupervised and becoming vulnerable in the community. Whilst this action may have been in the person's best interest, a decision made in line with MCA principals had not been made or recorded. We could not see evidence of separate MCA training, but were advised that this was covered in safeguarding training which staff had received. We spoke with the registered manager and operational development manager who told us that specific training would be implemented and the documentation would be updated.

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

We recommend that specific MCA training is provided to all staff and that the provider has systems in place to ensure that these principles are followed in practice.

People told us that staff sought their consent before carrying out any activity with them. One person said, "He (care worker) always asks if it is OK before he does anything." A relative told us, "I hear them (care workers) ask before they do anything." Where possible, people signed to say they had agreed to the support plan in place for them.

We checked training records and found that staff had undertaken training in moving and handling, safeguarding, health and safety, medicines, food hygiene and first aid. Training records were difficult to analyse and it was not possible to pull data from the electronic system such as the percentage of people who had completed specific types of training. This meant that the management overview of training was limited. This had been recognised by the provider and a new system for recording was being developed. Staff told us they received regular training and felt well supported but some staff said they had requested specialist training including, supporting people exhibiting behavioural disturbance, mental health awareness and care of people living with dementia and this had not yet been provided to them. Some staff told us they were working with people with complex needs. We spoke with the organisational development director who told us that they were looking for suitable training to meet the needs of all staff.

We were concerned that these training needs had been evident for some staff for some time and that they would not have access to this training imminently. For example, 30 out of 61 care workers had requested training at their appraisal in how to care for people living with dementia, and 37 had requested training in supporting people with mental health issues. One care plan stated that staff should monitor a person's mood due to their history of depression. There was no guidance as to how staff should do this, and we considered that this would be difficult for staff in light of their lack of training in this area. We judged that the response to the training needs of all staff had not been sufficiently swift, particularly for those staff who were supporting people with complex needs. We spoke with the organisational development director who told us they would ensure identified staff received sufficient guidance and information whilst the full training plan was being developed.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 18. Staffing.

A new programme of training had been devised and this was delivered by a local college, including training considered mandatory by the provider and new staff induction. The induction met the Care Certificate criteria for new staff. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care.

Specialist training was provided for people who used specialist equipment or medical devices or had a specific medical need. Where people received medicines and nutrition via Percutaneous Endoscopic Gastrostomy (PEG for example), staff were trained by a nurse to ensure they could do this safely and were supervised to ensure they were competent. A PEG is a form of specialist feeding where a tube is placed directly into the stomach and by which people receive nutrition, fluids and medicines. We also found that a nurse had trained staff in catheter care and visited them in the people's homes. This meant that training delivered was bespoke and relevant to the particular needs of the person. A catheter is when a tube is inserted into a person's bladder which drains urine. Effective catheter care is important to reduce the risk of infection or discomfort. Competency checks were not always documented but staff told us they had been assessed and that they had received appropriate training in this area.

Regular supervision and appraisals were carried out and staff told us they felt well supported. One care worker told us, "We have regular supervision and we can contact our mentor for advice if we need anything."

Care coordinators carried out quality spot checks of the service provided by care workers to ensure they were working to an acceptable standard. These checks were recorded.

People were supported with eating and drinking. The care workers we spoke with were clear about the support they needed to provide to people with eating and drinking. People and their relatives were happy with the support provided and told us, "They (care workers) get my lunch and make sure I have a drink before they go." A relative told us, "They (care workers) make sure (name of person) has something to eat and drink, this is peace of mind for us." Care plans contained information about nutritional risks and contact logs showed that care workers took action and reported to the office when they were concerned about nutritional intake.

People were supported by staff to attend health appointments where necessary and care records recorded people's medical history and whether there was ongoing involvement of health professionals. One person told us, "They take me to my appointment with the nurse. I just ring and tell them when it is." Systems had been improved following an incident in a person's home where their DNAR (Do Not Attempt cardiopulmonary Resuscitation) status was not evidenced by the correct paperwork in an emergency. We were advised that procedures for the storage of this information met with Northumberland County Council's preferred 'yellow envelope' arrangement making this easy to locate when required. A DNAR is a document issued and signed by a doctor which tells care and medical staff not to attempt cardiopulmonary resuscitation (CPR).

Good

Is the service caring?

Our findings

Feedback we received from people who used the service and their relatives about the quality of the care provided was overwhelmingly positive. People told us they had good relationships with the staff that supported them to live at home. One person told us, "They are very kind to me. They know me very well and know if I'm not well just by looking at me." Another person told us, "They are absolutely kind and caring. I am very happy when they are here." A relative told us, "They are smashing, lovely girls," and, "I couldn't do without these carers." There were numerous comments about the cheerful manner of staff. These included, "They are very happy; very chatty and helpful." Another person said, "They always seem to have a smile on their face."

We observed staff interacting with people and saw that they were kind, attentive, friendly and helpful. A number of compliments had been received by the service. We reviewed these and found that staff were praised for their kindness, respect, care and professionalism. A number of references were made during our conversations and also within compliments records about staff "going the extra mile." Where individual staff had been thanked we read in staff files that care coordinators had passed on these messages of thanks to the staff concerned and congratulated them for their recognition.

Staff were aware of the need to uphold privacy and dignity, and to maintain the confidentiality of information. A confidentiality policy was in place, which instructed staff to keep information about people safe and to screen from public view while in use, for example, when they accessed a property using a coded entry system. Circumstances under which information could be shared were clearly explained, Staff were aware of the need to maintain confidentiality. People told us their dignity was maintained. One person told us, "They sometimes help me dress and they are very respectful and make sure I'm covered up." A relative told us, "They treat (name of person) with great respect, although they still remain friendly. When helping her with personal care they respect her privacy and make sure doors and curtains are shut."

People told us they were supported to remain independent and carry out tasks by themselves where possible. One person told us they liked to prepare their own meals but care workers would do this for them if they were unwell.

An equality and diversity policy was in place. The policy outlined the commitment of the organisation with regards to protected characteristics including for example; age, disability, gender race, religion or beliefs as described in the Equality Act 2010. It included reference to one of the main aims of the organisation which included campaigning and advocacy on the behalf of older people. The service had access to specialist advice and guidance regarding services and support for people through the wider Age UK charity.

Staff supported people at the end of their lives. More detailed training in end of life care was planned, in line with a full review of training. We did not review end of life care plans during this inspection.

Requires Improvement

Is the service responsive?

Our findings

People and their relatives told us their needs were responded to. They said that visits took place on time, and they were contacted if carers were absent or running late. One person told us, "They always stay and do whatever I need. They have never missed a call." Another person said, "They are very punctual now. It has been a problem in the past." A number of people told us there had been an improvement in the reliability and consistency of the service. We asked whether people or their relatives had ever had cause to complain about the service. Most people told us they were very happy with the service and knew how to complain, but had never had to. Other people told us they had complained in the past, issues had been addressed and were no longer causing them concern.

A complaints procedure was in place. We reviewed complaints received by the service and saw these had been responded to within the timescales outlined in the complaints policy. Complaints records and responses varied in quality and detail. There was no standard recording format and the outcome of complaints or the action taken was not always recorded, or in a way which facilitated audits by the registered manager or provider. We were concerned about the apparent lack of action to some serious concerns. Action had been taken, but was not formally documented.

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

We spoke with staff who told us that they considered they provided a responsive and reliable service. One care worker said, "We try to look after the same people. We pride ourselves on continuity as much as possible. We have enough time between calls." Some staff told us they sometimes had to stay late with people, for example if they had become unwell or had experienced a fall for example. In this situation they had contacted a care coordinator who sent a replacement to their later calls, so they could wait for a relative or medical attention.

We spoke with care coordinators who told us they completed an assessment prior to people using the service to ensure the service could meet people's needs. Where possible, care workers were matched with people depending on their preferences and needs such as gender or particular skill set. People were allocated permanent care workers and we were told by care coordinators that there had been a decrease in what they termed "floating calls" where people were awaiting a permanent care worker. People told us they found their regular care workers responsive to their needs and reliable. One person told us, "I usually have the same ones (care workers) and they are definitely well matched for me."

Care records were person-centred. This meant that people's personality, behaviour, likes, dislikes and previous experiences were taken into account when planning care. People were consulted about their care plans where possible and we saw they were supported by relatives if necessary. Support plans in people's homes contained detailed outcomes to be achieved during visits. Care workers had signed to state they had read and understood care plans and we saw that people or their relatives had also signed them. One person told us, "I have a care plan, we do look at it regularly." There were some gaps in care records and some

pages in office based records were left blank. In one file, for example, a form entitled 'My values and things important to me' was not completed, although this could have been due to a lack of information being available upon referral. We found one example when we visited people at home, that care workers had adapted the care they provided to suit a person's changing needs, but this was not reflected in care records or reported back to office staff to ensure records reflected the current service. Most plans we reviewed were individualised and detailed however.

We recommend that systems for reviewing care plans and outcomes are sufficiently robust to pick up changes in people's care needs.

Staff supported people with social activities where this was identified as an assessed need. Staff supported people with a variety of needs including physical, psychological and social needs.
People were included and involved and offered choices about their care. Staff told us that they could encourage people to receive care as they might sometimes be reluctant due to their lack of understanding of their need to accept it, or because they were anxious or unsure. One care worker told us, "It isn't as simple as just accepting 'No', that can be someone's initial response, but with some tactful encouragement and some good humour, people can and do change their mind and feel better as a result." This meant all staff had a good understanding of how to adapt their response to people's varying needs while recognising choice and independence. They acknowledged that some people needed an extra level of support for their safety and comfort.

Requires Improvement

Is the service well-led?

Our findings

Following our inspection, we were informed that the newly registered manager had left Age UK and another manager had been appointed. The Chief Executive Officer had also left the provider organisation and Age UK was in the process of seeking a replacement. We were told this person would be registered as the Nominated Individual (NI) for the service. This means they would be registered with CQC as the person with overall responsibility for the provider.

The registered manager reported to the executive management team on a monthly basis and we saw minutes of previous board meeting minutes. The organisational development manager also attended board meetings to provide updates about the quality and safety of the service. They told us the service was going through a period of change and that improvements were being made to a number of systems. We acknowledged that a notable amount of work had gone into making the necessary changes, and the improvements had been commented on by people and relatives during our inspection. We were concerned however, that not all aspects of the service were well-led. When asked about the management of the service, people, relatives and care workers all expressed concern about the responses of some 'office based staff' which they described as being variable, depending upon who answered the telephone. One person said, "It depends who you talk to. Some [staff] in the office seem lost and don't seem to know what they are doing. Others are OK." Another person told us, "The care is outstanding, the management needs improvement." Several people including professionals and care workers, told us they had difficulty getting through on the telephone at times. This was despite increased office hours of 6AM until 10PM. One care worker told us, "My only moan is about the [staff] who answer the phones." Other care workers told us they found particular members of the management team very helpful, knowledgeable and professional, and valued their support.

A number of audits and checks of the service were carried out by the registered manager, care coordinators and senior care workers, including spot checks and checks of care records. Records which related to recruitment, MCA, complaints and training were not satisfactorily maintained and there were gaps in quality assurance systems which meant that not all of the shortfalls we identified had been recognised by the provider. Plans were in place to address some issues but the timescales involved meant that some aspects of the service were vulnerable to deterioration or unnecessarily prolonged period of risk.

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

Surveys were sent to people and their relatives to seek their views about the quality and safety of the service. Care workers told us they had been visited by a member of the management team to check their work. A staff survey had not been sent as staff were working closely with the provider about proposed changes to their working terms and conditions. A consultation group of 16 staff had been selected to represent the views of their colleagues and regular written updates were sent to all staff. Staff felt they were being listened to and their views sought throughout this process.

Plans were in place to review and amend the existing training provided, although this was not fully

implemented at the time of our inspection. There were also plans to improve the recording of electronic data from visits, where staff would 'tag' in and out of calls using a mobile telephone and record the tasks completed. The application would also alert the office staff to any safety concerns arising from lone working or missed visits. Currently if staff forgot to 'tag' out of a call or didn't have a signal there was no way of knowing that they had got home safely which undermined the lone working policy that the provider had in place. There were also difficulties with telephone signals in very rural locations which also impacted upon this. It was hoped the new system would address this issue and that it would be introduced in early 2017.

The service worked in partnership with other agencies including meeting on a regular basis with other Age UK branches to share best practice and learn from each other's experiences.

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 17 HSCA RA Regulations 2014 Good governance Records were not satisfactorily maintained in relation to recruitment, training, MCA and complaints. Systems to monitor the quality and safety of the service had not picked up all the shortfalls we identified. Regulation 17 (1) (2) (a) (b)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff were not always fully supported to undertake training, learning or development to enable them to fulfil the requirements of their role. Regulation 18 (2) (a)