Quality Home Care (Barnsley) Limited

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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

Quality Homecare (Barnsley) Limited is a domiciliary care agency registered to provide personal care for people living in their own homes.

At the time of the inspection the agency was supporting approximately 137 people, equating to approximately 1497 hours. As part of our inspection we telephoned 26 people to obtain their views of the support provided. Five of the telephone numbers supplied by the agency were incorrect. We were able to speak with seven of the people we telephoned and seven relatives. Prior to our inspection at the office base, we visited five people in their own homes. On four of those visits, relatives were in attendance and we also spoke with them.

Summary of findings

At the time of this inspection the service employed 60 staff. We telephoned 12 staff to obtain their views and experience of working for this agency. Three of the telephone numbers provided by the agency were incorrect. We were able to speak with four staff.

We told the provider two days before our inspection that we would be visiting the service. We did this because the manager is sometimes out of the office and we needed to be sure that they would be available. During our inspection we spoke with the registered manager and a member of staff responsible for the oversight of quality assurance for the service.

There was a manager at the service who was registered with CQC. 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 and associated Regulations about how the service is run.

At our previous inspection on 7 July 2014 we had asked the registered provider to improve requirements relating to workers, assessing and monitoring of service provision and records. This was because there were breaches of those regulations, which may have placed people who used the service at risk of unsafe or inappropriate care. The registered provider sent us action plans stating the improvements they would make to comply with those regulations.

At this inspection we found the provider had made improvements in those areas.

There were mixed responses from people and their relatives about whether they were visited by a consistent team of staff. Some people told us they received care from staff that they knew well and they had a team of regular, reliable care staff that visited them. Others told us contrary to this. Likewise, some people told us their care staff were kind, caring and considerate, others had received occasional care that didn't reflect those values. Our discussions with care staff demonstrated familiarity and knowledge of people's individual needs, life history, their likes and dislikes and particular routines.

Care staff had a good understanding of what to do if they saw or suspected abuse during their visits. They were clear that this must be reported to the manager of the service and were confident they would act on that information. We saw this was a regular agenda item at staff meetings.

We found systems and processes in place for the safe recruitment of staff, with information and documents to support this.

We found safe systems and processes in place for the management of medicines.

Most people and relatives we spoke with told us they were confident staff had the knowledge, skills and experience they needed to carry out their roles and responsibilities. Staff confirmed they were trained prior to providing care and support to people who used the service and following initial training felt supported in their job role. We found there were some gaps in the training requirements of some staff.

We received no information that staff at the service had not followed the requirements of the Mental Capacity Act 2005 Code of practice, but staff's understanding in this area needed to improve.

People who used the service had an assessment of their needs, a plan of care and risk assessments in place to identify any potential risks to people. We found these were not always signed and dated for accuracy and in case of challenge at a later date.

There were systems in place to monitor and improve the quality of the service provided. People who used the service and their relatives were asked for their opinion of the service via surveys. During this inspection we were able to see evidence of the information included in reports about the quality of service provided.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. This corresponds to two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

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

The service was not consistently safe.

People told us they felt safe and care staff had a good understanding of what to do if they saw or suspected abuse during their visits, such as reporting the information to the manager of the service.

Risks to people and the service were managed, so that people were protected, whilst at the same time respecting people's choices to take risks.

The service had made sure there were sufficient staff to provide a regular team of care staff and on this inspection all the required recruitment information and documents were available for those staff. People reported that improvements were needed with the flexibility of calls.

The service had systems and processes in place for the safe management of medicines.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff told us they were trained prior to providing care and support to people who used the service and following initial training felt supported in their job role, but improvements were needed with the provision of some training.

Staff supported people to have access to healthcare services as required and monitored and encouraged people at risk of poor nutrition.

Is the service caring?

Good

The service was caring.

Most people told us they were treated with consideration and respect and the staff knew them well.

Staff were familiar with people's individual needs and were able to describe how they maintained people's privacy and dignity.

Is the service responsive?

Requires Improvement

The service was not always responsive.

On this inspection improvements had been made with assessments, risk assessments and care plans and they reflected people's personal preferences, but consistency needs to be applied with the signing and dating of documents so that everyone's care is provided in accordance with their plan.

Summary of findings

People and relatives told us when they raised any issues with staff and managers, their concerns were listened to, but the complaints process needed to improve with a clear process following the pathway, timeline, investigation, resolution and response as identified in the complaints procedure.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There were quality assurance and audit processes in place to aid the registered provider in making improvements at the service, with evidence that improvements in collation of data had been made since the last inspection.

The service had a full range of polices and procedures available to staff.

People and staff told us managers at the office were not always approachable and communication at times could be improved.

Regular team meetings took place where staff could discuss various topics and share good practice.

Quality Homecare (Barnsley) Limited

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.

This inspection took place over four days on 21, 22, 23 and 26 January 2015. The registered provider was given two days notice of our visit to the office on 26 January 2015. We did this because the registered manager is sometimes out of the office and we needed to be sure that they would be available. During our inspection we spoke with the registered manager and a member of staff responsible for the oversight of quality assurance for the service.

An adult social care inspector, specialist advisor and an expert by experience carried out this inspection. Our specialist advisor had knowledge and experience as a previous registered provider. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service. This included the service's inspection history, correspondence we had received about the service and notifications submitted by the service. We also sent a provider information return to the registered provider prior to the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also contacted commissioners of the service and Healthwatch. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. This information was reviewed and used to assist with our inspection.

At the time of the inspection the agency was supporting approximately 137 people, equating to approximately 1497 hours per week. As part of our inspection we telephoned 26 people to obtain their views of the support provided. Five of the telephone numbers supplied by the agency were incorrect. We were able to speak with seven of the people we telephoned and seven relatives. Prior to our inspection at the office base, we visited five people in their own homes. On four of those visits, relatives were in attendance and we also spoke with them.

At the time of this inspection the service employed 60 staff. We telephoned 12 staff to obtain their views and experience of working for this agency. Three of the telephone numbers provided by the agency were incorrect. We were able to speak with four staff.

We also spent time looking at records, which included ten people's care records, three staff records and other records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

At the last inspection on 7 July 2014 the service was in breach of the regulation for requirements relating to workers. The provider sent us an action plan stating the improvements they would make to comply with those regulations. We checked to see if improvements had been made.

We found improvements had been made to the recruitment and selection procedure. We found information required by legislation was obtained before staff commenced employment. For example, proof of identity, a Disclosure and Barring Service check (this means checking the criminal record of staff), satisfactory evidence of conduct in previous employment in relation to previous work with vulnerable adults and/or children in health or social care, proof of qualifications, a full employment history and satisfactory information about people's physical and mental health conditions relevant to the work. The three staff files checked contained all the relevant information.

We checked the systems in place to protect people from harm and abuse. People we spoke with told us they felt safe when they were being cared for by staff. One person said, "They've [staff] never done anything that's not natural." A relative said, "[Relative] can get aggressive, but [relative's] safe with carers. [Relative] gets on well with them."

We found safeguarding and whistleblowing policies and procedures in place, including access for staff to South Yorkshire's local joint working protocols to ensure consistency in line with multi agency working. Whistleblowing is one way a worker can report suspected wrong doing at work by telling a trusted person in confidence. The policy and procedure for handling money and financial matters on behalf of a service user had also been updated following two allegations of financial abuse. These were still being investigated. The registered manager told us the service currently were not involved in any financial transactions on behalf of people who used the service.

Since the last inspection the local authority had been made aware of five allegations of harm where people had been placed at risk of poor or inadequate care, such as staff overstepping professional boundaries, allegation of financial harm, documents being removed from a person's property and a missed call. The registered manager had taken action, for example, notifying the appropriate authorities, investigating where requested to do so and following up where necessary with disciplinary action of staff.

Staff told us and records confirmed staff received safeguarding and whistleblowing training. One member of staff was assured the registered manager would take action regarding any allegations of abuse, because they themselves had received disciplinary action for placing someone at risk of harm.

We checked the systems in place to see how risks to people were managed, so that people were protected, whilst at the same time respecting and supporting their freedom.

When we spoke with people and their relatives they were confident that care staff were competent and aware of risks that may be presented and managed these well. One relative told us they were concerned that only one member of care staff attended to their relative and they needed the use of equipment to move safely, which they felt was unsafe. We viewed that person's care file and found the service to be provided had been re-assessed as requiring only one member of care staff. This identified a lack of communication in communicating changes in people's care to them and involving them in the process.

In other files we viewed we found assessments had been undertaken to identify risks to people who used the service. These included environmental risks and other risks due to the health and support needs of the person. For example, some people had needed assistance to move and information was provided to staff about how to support them when moving around their home and transferring in and out of chairs and their bed. We found the risks identified had been regularly reviewed and it was clear what the risk was and the action to be taken to minimise the risk.

The service had a contingency plan in place for the action to be taken in the event of emergencies. For example, outbreak of contagious diseases. The plan identified the list of potential emergencies and an advance plan should those emergencies arise. This meant the service had

Is the service safe?

considered the impact of emergency situations on them in relation to the care and welfare of people in the care and had plans in place to mitigate any risks to people should an emergency occur.

We checked to see there were sufficient numbers of staff to keep people safe and meet their needs.

People and their relatives told us that they were informed if staff are going to be a bit late due to unforeseen circumstances.

When we spoke with people several thought that the service was short-staffed and that there were a lot of changes with good staff leaving. People accepted that they did not know who was coming to their home unless they were told by the care staff.

Three people told us of the lack of flexibility within the service. For example, one person told us they had repeatedly asked for a later bedtime call, which hadn't happened. They told us they were 'resigned' to the existing arrangements. Another person also told us they would prefer a later call, but told us that it had never happened and now they are used to the earlier time. Another person told us they had asked for an earlier morning call to assist them in getting to a regular hospital physiotherapy appointment, but the agency could only offer an extremely early time.

A relative also said they'd asked for an earlier night time call, because they went to bed, but the agency couldn't go earlier.

One relative told us they had checked the care records and found that for the 15 minute calls identified as needed, care staff were staying for only 3-7 minutes. They had contacted the office and during the last few months care staff were staying the full 15 minutes. Another person told us that a call had been missed, but they had rung the office and it was resolved.

In contrast other people and relatives said, "It seems to be the same carers if you look at the records," "I have regular carers, dependant on personnel. They're very good with the times and the length of time they stay. If there's a problem I get a telephone call" and "There's a big turnover of staff, but I understand it's the industry. It's the minimum wage and you can't help that. Generally times are ok, but there is times when they're late, but what they don't do is look at the next call. For example, one day the breakfast call was 10 – 10:30am and as I was leaving a couple of hours later they were coming to do lunch call. They don't often miss though."

When we spoke with staff they told us they worked in teams, covering a specific number of people. Any member of staff in the team could visit any person in that particular team. They told us this was so that people knew staff that may be coming and that staff knew each person's care needs should they be required to cover. One team member we spoke with thought they were slightly understaffed for the hours they needed, but they worked as a team to cover. This meant they were working more than the Working Time Directive (WTD), but said staff had a choice about working longer hours. We also saw from timesheets that some staff were working more than 48 hours per week. The WTD is that workers aren't required to work more than 48 hours per week average by law, unless they choose to. There was no declaration on staff files to confirm they'd agreed to opt out of the WTD.

This meant the registered person had not deployed staff in a way that meets the needs of all people using the service. This was a breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We checked to see how people's medicines were managed. We found systems and processes were in place, so that they received them safely.

When we spoke to people or their relatives we found some people relied on care staff to remind them to take their medication and they told us this seemed to work well with staff recording this on medication administration records.

We found people had medication plans in place and that risks associated with medicines had been carried out for each person. We found the plan identified the level of assistance that people required and the medicines to be administered. When we checked the medication administration record we found medicines had been administered in accordance with the medication plan.

Requires Improvement

Is the service effective?

Our findings

We checked to see if staff had the knowledge and skills they needed to carry out their roles and responsibilities.

When we spoke with people and their relatives most people thought that the staff had enough training to do the job and that when new carers started they shadowed an experienced worker at first. However, one person told us that the carers did not how to make a bed with a crib despite them explaining this. One person said, "The majority of staff are quite willing but are not given enough training." One relative had given an information sheet to the agency about their particular relative's condition, but felt that the staff who visited had not read it or did not understand it.

The service employed their own training officer to provide training. Staff we spoke with told us they had received an induction and been provided with training in key topics, including, health and safety, safeguarding, moving people, record keeping, medication, infection control, equality and diversity, pressure area care, food hygiene and catheter care. We saw that only seven of the 63 staff had received emergency aid training and 37 had received mental capacity training. These topics are essential for all staff in their roles and responsibilities of providing personal care to people who live in their own homes. We saw that certificates were awarded for successful completion of these topics and that these were available in the staff files as well as on training records, used to monitor when staff required their training to be updated.

The registered manager provided the supervision policy for staff, which identified staff would receive supervision at least three to six monthly and this would include an observation of the member of staff's performance. Supervision is an accountable, two-way process, which supports, motivates and enables the development of good practice for individual staff members. This was confirmed when we viewed staff records and spoke with staff.

When we spoke with the registered manager she told us appraisals were not carried out. The main purpose of appraisal is to give the appraisee the opportunity to reflect on their work and learning needs in order to improve their performance. The manager said this opportunity was provided through the supervision process.

Mental Capacity Act 2005 (MCA) is legislation designed to protect people who are unable to make decisions for themselves and to ensure that any decisions are made in people's best interests. Deprivation of Liberty Safeguards (DoLS) are part of this legislation and ensures where someone may be deprived of their liberty, the least restrictive option is taken. We found the MCA had been discussed at a team meeting where the registered manager had explained what the Act was about and who it protected. However, not all staff had received this training and when we spoke with staff not all staff were able to explain the principles of the Act and how this might impact on them in their role.

This meant the registered person had not provided all the training needed for staff, to enable them to appropriately perform the duties required of their role. This was a breach of regulation 23 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with told us that staff supported them where necessary to eat and drink, but one person we spoke with told us that one of their carers did not have basic cooking skills. Where staff supported people with their food and drink we saw that they recorded this information in people's records, so that this could be monitored and if necessary they and other professionals had information to make decisions about future support with eating and drinking.

In the main, people and relatives we spoke with told us that where necessary staff supported people to attend health care services, so that concerns about their health could be monitored. Staff told us that if they attended to provide care for people and they were unwell, they would ensure this information was passed on to the most appropriate person, so that people received healthcare support when needed.

Good

Is the service caring?

Our findings

We checked to see that people and their families experienced care by staff that treated them with compassion, kindness, dignity and respect.

Most people we spoke with felt that the care staff were kind and respectful and had a good relationship with them. They told us care staff knocked on their door before entering and were respectful of their dignity. Comments included, "They certainly care for me. It's a two way thing. I try and run a good ship. They work hard at looking after me. I'm open with them about what I need. I know myself what's involved in my care and they work to it. They do a good job," "I'm totally dependant on care, four times a day and I'm quite at ease with my care. I've no concerns with the conduct of staff in the last few years, it's quite steady," "I get on very well with the carers – they quickly become friends as well as carers," "They do an excellent job," "I'm very satisfied. Couldn't wish for any better carers. They help us in any way they can", "The lads are good", "I think they're doing a good job," "They're very jolly," "Most carers are brilliant" and "I'm quite satisfied. They stand a joke from me and I stand a joke from them."

One relative explained their family member was helped into the shower and then given time and privacy to soap themselves as much as they could, promoting the independence they had. Other comments included, "We've found them fine and [relative] says they're nice girls," "I think they're brilliant. Anything you want doing they'll do. They're right caring and they go above and beyond," "It's amazing the way they speak to [relative]. They look rough, but they're so kind. They don't patronise [relative]. I can't speak highly enough of them. They put me at my ease and they don't rush. They joke and have banter with [relative]. [Relative] likes them. They're professional, whilst at the same time friendly, but not over familiar. They're very knowledgeable and give me reassurance. I never feel there's any risk" and "I've heard a bit of banter between them. They're very caring. They ring me when they've had to get a doctor. I've seen they maintain [relative's] privacy and dignity. I'm happy with the care plan."

During our visits and discussions with people and their relatives it was clear staff were familiar and knowledgeable about people's individual needs, life history, their likes and dislikes and particular routines. People and their relatives were able to tell us how staff were concerned about any changes to their health and well being and what they liked and disliked. They gave examples of how staff treated them with dignity and respect and maintained their privacy. The examples they gave included making sure curtains and doors were closed and making sure people were appropriately covered when providing personal care.

People were provided with a service user guide to explain the standards they can expect from care staff working for the agency. The information included information about advocacy services, should they need or wish someone to make representations to the service on their behalf.

We spoke with staff and asked them to describe how they treated people with compassion, kindness, dignity and respect. Comments included, "It's all about the service user and what they want. You allow them to take risks. You introduce yourself and make sure you maintain their privacy and therefore dignity by closing blinds when you take them to the toilet," "I like to think I make a difference to people's lives, make it easier for them" and "Helping someone who can't help themselves. Introduce yourself and always explain what you're doing. Make sure there's no-one else in the room when providing personal care, unless it's at the request of the person and make sure curtains are closed."

Requires Improvement

Is the service responsive?

Our findings

At our last inspection on 7 July 2014 the registered provider was in breach of the regulation related to records. The provider sent us an action plan stating the improvements they would make to comply with that regulation. We checked to see if improvements had been made.

Most people and relatives we spoke with told us they thought the service from Quality Homecare (Barnsley) Limited provided them with care as agreed. When we spoke with people we found most care was provided after a discharge from hospital or through arrangements made with social services. This was confirmed by the registered manager, who said the care provided was based on that information. This meant the initial assessment was often undertaken at the same time as the service commenced. People and relatives were generally aware of the arrangements that had been made. One person we spoke with explained they had expressed a preference for male carers at this time and this had been respected. Another said, "We're happy with the arrangements that have been made."

However, one person told us they had received a telephone call to say that their carer would be late and would not arrive for their breakfast call until 9.45am -10am. The member of staff arrived at 10.25am. They told us the member of staff usually took them shopping for two hours, but on this occasion told them they had a personal matter to attend to and would prefer to take a shopping list and do the shopping for them, which the member of staff said had been agreed with the manager. The person was already ready and looking forward to going out so insisted that the member of staff take them. This meant this member of staff had tried not to promote the person's independence and deliver the care as planned and agreed.

Most people were aware of their care plans and told us they were reviewed annually with social services. This was confirmed when we looked at people's care files in their home. When we reviewed the care files of the people we had visited and sampled the care files of two other people we had spoken with, we found care files consistently had assessments and risk assessments in place with a care delivery plan, which meant we could identify when that particular service had commenced. We found that the care plans, assessments and risk assessments had not been dated or signed to evidence they were accurate and fully completed. We found the information in people's care files reflected the care delivered that people and their relatives had explained to us.

We spoke with one relative who explained the care plan for their relative had recently changed. They were unable to explain what those changes were or that they were satisfied with them because they had not been consulted by either social services or Quality Homecare (Barnsley) Limited. The person receiving care was living with dementia and was unable to recall for their relative what arrangements had been made in regard to their care provision. With their agreement we raised this with the manager of the service as a concern, as they had not had an opportunity to do this. The manager initial comments was an assumption that as the care is commissioned by the local authority, the changes would have been discussed with the appropriate people involved with their care. This meant changes to the person's care had not been made with the involvement of people and their relative or communicated to them.

In people's care files we found the service user guide that provided information to people and their relatives about the service. This included the complaints policy and procedure.

When we spoke with people and their relatives they told us when they had raised any concerns or complaints they felt that they had been resolved. For example, one person told us that a call had been missed, but they had rung the office and it was resolved.

When we spoke with the registered manager she told us all complaints referred to the office would be logged. We saw this complaints log during the inspection. The registered manager said the complaint would then be investigated and the outcome of the investigation recorded and shared with the person making the complaint. They explained the outcome would be shared using the same method of communication the complainant had used to make their complaint initially. We found this was not explained in the provider's procedure, which meant that people were not provided with full information.

When we reviewed the complaints that had been made we found no clear process, with an ad hoc method of recording that did not follow a pathway, timeline, investigation, resolution or response as identified in the

Requires Improvement

Is the service responsive?

complaints procedure. The form to record the initial complaint did not include a record of the member of staff who took the complaint. There were additional documents attached to the original complaint. It was not clear what each of the documents were, having to read the narrative to arrive at a conclusion. For example, there were statements from the person making the complaint and the person being interviewed, but the form did not clearly identify this. Neither was the name of the interviewer identified, just a signature, with an assumption, people reviewing the document would know who those names referred to. Documents/pages were not numbered, therefore there was not a clear chronology of the sequence of events and questioning.

There were few complaints recorded. We found that some lower level complaints or concerns were not recorded, but dealt with locally. For example, on one of our visits we saw recorded in the daily records a concern raised by a relative about the time of calls being changed from those agreed, with no consultation and that this was not acceptable as it did not meet the care needs of the person. Whilst the concern was rectified, staff had not identified this as a concern and reported it as such, and no-one had spoken with the relative. Another relative told us of notes they left, but they never got a call to discuss them.

Also, when we spoke with staff they were not all consistent in how they would deal with a concern or complaint. For example, some staff said in the first instance they would deal with it and only escalate if they were unable to resolve it and other staff said they would report all concerns. This confirmed that staff reported concerns inconsistently and meant the service would not have an overview of all the concerns and complaints received.

We discussed our findings from our review of the complaints system and process with the manager at feedback and identified the areas needed for improvement.

We found the system for recording compliments to be much more robust and found when these referred to staff, reference was also made in staff files.

This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Requires Improvement

Is the service well-led?

Our findings

The registered service had not maintained consistency in meeting regulations. At our last inspection on 7 July 2014 the registered provider was in breach of recruitment of workers, assessing and monitoring the quality of service provision and records. The provider sent us action plans stating the improvements they would made to comply with those regulations. On this inspection we found those improvements had been made.

When we spoke with people and their relatives we asked them about the management and leadership of the service and the systems they used to identify whether a quality service was being provided. We found several people we spoke with had not met the manager and only some knew the senior carer for their team.

Everyone we spoke with knew how to contact the office and would do so if necessary. However, some people were not satisfied with the response and so felt it was 'pointless to ring the office'. Some said 'messages were not passed on'.

Not everyone who received a service said they would recommend the service to others.

People we spoke with were aware of occasional surveys. One person felt a recent survey restricted responses. For example, they explained one question asked for a rating of how good you rate your carers. They said if two out of three are good, but one is poor, how can your answer reflect that.

Other comments about the management and leadership of the service included, "It seems well run. I've had my 'run ins' in the past, but it seems to have settled down. If there's something bothering me someone from the office will visit. [The manager] will be there if needed" and "Manager seems clued up, even though a bit coarse."

We found that inaccurate information regarding people's contact details had been provided to us. For example, the agency had not completed the details of all people who used the service and staff as identified on the contact list and there were five incorrect telephone numbers for people who used the service and three incorrect telephone numbers for staff.

The registered manager and member of staff responsible for quality assurance explained the systems in place to assess and monitor the quality of the service and provided the quality assurance policy/procedure. This included a person responsible for quality assurance making telephone calls, sending out surveys and visiting people to assist with this if necessary and visiting every person yearly to seek feedback for improvement. In addition, care plans would be reviewed at least yearly and staff will receive four supervision meetings a year including an observation of their practice. Meetings for staff would be held four times a year.

At the last inspection we saw the most recent quality assurance summary report for 1 April 2013 – 31 March 2014 which was produced on 27 April 2014. At that time we found no raw data to support the statements in the report, nor how the statements had been arrived at. In addition, that the actions identified were carried out, for example, the dissemination of the report and actions to people who used the service and staff.

On this inspection we found a data management system had commenced to support the data that would be used to complete the report. We were able to cross reference the entries with completed survey forms.

We noted the quality assurance survey was for the most part quantitative and there was a prompt for the person's name, date and area from which they were responding. A separate last page again requested the respondents name. This contradicted the quality assurance policy statement that clearly stated the survey was anonymous. We discussed this with the member of staff responsible for quality assurance who appreciated the anomaly and said they would amend the policy and procedure to accurately reflect the procedure they followed.

We found observation of staff practice had taken place as part of their supervision. This meant the registered provider had systems in place to check staff were carrying out their role as required and were competent in performing those tasks. In addition, it provided the person receiving care with the opportunity to comment on their opinion of the service provided.

Our visits to people's homes and a review of their care files confirmed people had received a review of their care plan as identified in the quality assurance process.

Since our last inspection staff had, had the opportunity to attend two staff meetings. We looked at the staff meetings and items such as confidentiality, safeguarding, rotas, care plans, gifts/gratuities and concerns were discussed. This

Requires Improvement

Is the service well-led?

meant feedback was provided to staff of improvements that were needed or changes to policies and procedures. Staff told us the agenda of the meetings changed dependant on what discussions needed to be held. We also saw for the last two staff meetings the service had recorded the names of staff who attended, which meant discussions with staff could be held to validate the minutes as a true reflection of the discussions that took place. This meant the service had learnt from improvements required from the last inspection.

The service had policies and procedures in place which covered all aspects of the service. The policies and procedures had been updated and reviewed as necessary, for example, when legislation changed. Staff told us policies and procedures were available for them to read and they were expected to read them as part of their training programme.

When we spoke with staff they were clear about their roles and responsibilities. When we asked them about their work at the agency they commented, “We think we’re a good agency, but I believe every day we could be better, because you’re always learning,” “The managers are approachable – it depends on their mood, but they listen,” “It’s a good staff team. We work for each other,” “We have good support” and “I’m confident in the management. They seem on the ball.” Staff said they were able to voice any concerns they had.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 16 HSCA (RA) Regulations 2014 Receiving and acting on complaints How the regulation was not met: The complaints system was not effective in establishing an accessible system that clearly identified and recorded the complaint being made and by whom, how the complaint was being handled and by whom and responses to the complainant about the action taken in response to any failure identified by the complaint or investigation.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing How the regulation was not met: The provider had not deployed staff to make sure that they could meet people's care and treatment needs. All learning and development and required training had not been sufficiently monitored and appropriate action taken quickly when training requirements are not being met. This meant all staff had not been provided with all the training relevant to their role.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.