Care Quality Commission

Nestor Primecare Services Limited

Allied Healthcare Barnstable

Inspection report

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Ratings

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

Overall summary

This inspection took place over three days on 1, 2 and 3 December 2015. The inspection was announced and we gave 48 hours notice. This was because the location provides a domiciliary care service and we needed to make sure the registered manager would be available during our visits.

We previously inspected this service on 4 and 5 February 2014 and judged the five key areas we looked at compliant.

Allied Healthcare Barnstaple provides personal care and support to people living in their own homes in the North Devon areas of Barnstaple, Bideford, Ilfracombe and the surrounding areas. At the time of our inspection there were approximately 107 people receiving a service. The times of care visits ranged from 15 minutes to two hours. The frequency of care visits ranged from two to 28 visits per week.

There was a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements of the HSCA and associated regulations about how the service is run.

Staff were recruited safely and received the appropriate training and supervision to do their jobs properly. Staff

Summary of findings

treated people with kindness, dignity and respect so people felt safe and cared for in their homes. Staff received training on, and understood the principles of, the Mental Capacity Act (2005). However, there was not always enough care staff at Allied Healthcare Barnstaple to care and support people safely and meet their needs in a timely way. This resulted in late calls and care staff being rushed. Care staff and the management team worked extra hours to cover the shortfalls.

People were asked for their consent from care staff before any care or support was given. People felt safe with their regular team of care staff who knew how to protect people from abuse and how to report any concerns.

People felt involved in decisions about their care; each person had care records which included an assessment, a care plan and the necessary risk assessments in place. People received their medicines as prescribed. Staff received training on how to give medicines out safely. People's health needs were monitored and referrals made to health care professionals were made when necessary.

People knew how to make a complaint if they needed to. All complaints were monitored and investigated appropriately.

There was a clear management structure and a management team in place. Some staff reported there was low morale and they were not supported or motivated in their jobs. However, the registered manager was in the process of putting plans in place to recruit more staff, make organisational changes, improve the flexibility of the service in order to help improve staff morale.

There were effective systems in place to regularly monitor and improve the quality of the service; through audits and feedback from people and their relatives who used the service.

We found one breach of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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?
The service was not always safe.

There were not always enough staff to care for people safely and in a timely way to meet their needs and preferences.

Risk assessments were in place to protect people from risks associated with their care and health.

People were kept safe by staff that had a good knowledge of how to protect people from harm.

Medicines were managed safely and people received their medicines as prescribed.

Requires improvement

Is the service effective?
The service was effective.

People were cared for and supported by staff who had the right skills and knowledge to care for them. Staff had received the appropriate training to care for them and meet their needs.

Staff asked for consent before they carried out any personal care. They had received training on the Mental Capacity Act (2005) and had a good understanding of how it applied to their practice.

Good

Is the service caring?
The service was caring.

People were supported by kind and caring staff.

Staff knew how to treat people with respect and dignity.

People were able to make choices about their care and their independence was maintained.

Good

Is the service responsive?
The service was responsive.

People were involved in decisions about their care and how they wished to be supported.

People had an assessment and care plan in place.

People knew how to make a complaint and who to speak to if they had any concerns. Complaints were monitored and investigated appropriately.

Good

Is the service well-led?
One aspect of the service was not well led.

Requires improvement

Summary of findings

Due to recent staff shortages and organisational changes, staff did not always feel motivated and supported and there was low staff morale. However, management had begun to put plans into place to rectify the issues.

There was a clear management structure in place.

There were systems in place to monitor and improve the quality of the service.

People's views were regularly sought about the running of the service.

Allied Healthcare Barnstable

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 over three days on 1, 2 and 3 December 2015. The inspection was announced and we gave 48 hours notice. This was because the location provides a domiciliary care service and we needed to make sure the registered manager would be available during our visits.

The inspection team consisted of two adult social care 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 service.

Before the inspection, we looked at the information we held about the service. This included notifications the service had sent us. A notification is information about important events which the provider is required to send us by law. The provider completed a Provider Information Return (PIR). This is a form that asked the provider to give some key information about the service, what the service does well and the improvements they plan to make. The Care Quality Commission sought feedback via a questionnaire to people and their relatives, health and social care professionals and staff to gain their views of the service provided. We sent 50 questionnaires to people and their relatives of which 20 were returned, 8 to health and social care professionals of which none were returned and 35 to staff of which 7 were returned.

During our inspection we spoke with 17 people receiving a service, of which nine were visited in their own homes. We spoke with five family members, one friend and 14 members of staff which included the registered manager, two care co-ordinators, a field care supervisor and care workers.

We reviewed a range of records about people's care and how the service was managed. These included eight people's care and medicine records, eight staff recruitment files, staff training records, minutes of meetings, complaints/compliments and a selection of policies and procedures relating to the management of the service. Following our visit we sought feedback from six health and social care professionals to obtain their views of the service provided to people. They did not respond to our request for information.

Requires improvement

Is the service safe?

Our findings

We received mixed feedback about whether people had a regular team of care staff who arrived on time and did not miss calls to their home. Seventy eight per cent of people who responded to our questionnaire said they received care from familiar and consistent care workers. However, people we spoke with talked about repeated late care calls from staff, changes in the care worker rota and staff visiting them who they had not met before. Comments about late visits included: "It's not the care workers fault but it's (the time) not long enough … they're always late … yesterday they were well and truly late by almost an hour and I rang but there was no good reason … I'm not really happy as I would like to change the times of the visits", "I have a team of three regulars and if one can't come (the co-ordinator) comes herself" and "I have two carer's who alternate and if they can't come, (a co-ordinator) will come but a while back no-one turned up and we did complain."

One family member said: "I don't like to complain but if the usual worker has to go off sick they don't inform us and a stranger turns up and recently it's happened a lot … (my relative) has panic attacks if there are changes." Another family member said there were no staff to cover when their relative's regular care workers were not available. This had impacted on the family member who said they were unable to go away in case they had to support their relative. One person told us they had missed their weekly shopping visit from a volunteer worker due to the care worker who arrived at the wrong time for their visit. Another person said their morning visit was delayed so much that it ran into their lunchtime visit. They commented: "I had been waiting and waiting … someone arrived at 11:00am but then another turned up at 12:00pm."

Staff said they had to visit people who they had not met before and often had to 'double back' on themselves to attend an unplanned care call. One care worker said: "I have to go in blind sometimes" and another said: "There's times we get frustrated … ninety five per cent we stick to the rota but then you're only given short notice to cover for people who are sick … and if you're driving and talking you don't realise where it is."

During our visits to the office, the telephone rang constantly and both co-ordinators and the registered manager took these calls. The co-ordinators had to change the rota several times due to changes in staff availability, staff sickness and other circumstances such as hospital admissions. One care worker did not turn up for work at 7:00am and did not inform the out of hour's service. The care calls had to be covered by the field care supervisor when they arrived for work which meant the care provided was late. Another care worker also rang in sick and the co-ordinators had difficulty in covering the shifts due to a lack of available staff. The family member was contacted to alert them that the calls to their relative would have to be cancelled unless a care worker could be allocated. This meant people's safety and well-being was put at risk.

We discussed the lack of available staff with the registered manager. They said the staff rotas had, over the past few months, needed to be regularly changed due to staff shortages, sickness, annual leave and staff leaving the service. This had left the service short-staffed and staff were working extra shifts to cover. The co-ordinators said they always tried to let people know of staff changes but due to their workload, this had sometimes been overlooked. There was an on-going staff recruitment plan in place to fill the shortfalls. Care packages were handed back to the local authority if enough staff were not available in a particular area to cover calls safely.

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

The service used a centralised out of hours on-call service. We received negative comments from people and care staff about how the service responded when the out of hours service was contacted. One person commented: "They don't understand what I am saying and ask for my postcode and lots of details". One person, who also had some care provided by another domiciliary care agency, said they would contact that agency and ask them to call Allied as they were much happier with their response to them.

Staff told us the out of hours service did not work efficiently and was not consistent. The local management team said it could be two hours before the centralised out of hours team informed them of a missed or late visit. One person said they expected a care call at 8:40pm but the care worker was delayed and they had not been informed. The care worker arrived at 9:30pm by which time the person had gone to bed and they missed their visit. On one occasion, a care co-ordinator said they were contacted by the out of hours service when a care call had been missed. They themselves travelled some distance to cover the care

Requires improvement

Is the service safe?

call. When they arrived they found a care worker was there; the out of hours had not let the co-ordinator know they had covered it. We discussed this with the registered manager who was aware of the problems with the out of hours on call service and had previously voiced concern about the service to senior staff. Following the inspection, a planned change of the out of hours service agreement had been made. The registered manager had received positive feedback about the improved service from people and staff who reported that it was working more efficiently than the previous agreement.

An up to date safeguarding policy and procedure was in place which included local guidance for staff to follow. All staff had received safeguarding training and were knowledgeable in how to recognise signs of potential abuse and who to report the concerns to within the organisation and externally such as the local authority, Police and the Care Quality Commission. The registered manager informed us any concerns regarding the safety of a person would always be discussed with the local authority safeguarding adults team and referrals made when necessary. A whistleblowing policy was in place to give guidance to staff.

Assessments were undertaken and in place to assess any risks to people who received a service and to the care workers who supported them. This included environmental risks and any risks due to the health and support needs of the person such as falls, manual handling and nutrition. Risk assessments included information about the action to be taken to reduce the chance of harm occurring. The provider had contingency plans in place for managing risks to the delivery of the service in the event of an emergency, such as flooding. People were risk assessed based on their level of need and prioritised on a traffic light system; this ensured the most vulnerable people received their care calls during an emergency.

People told us staff always left the premises secure and closed doors, windows and gates behind them. Where people were unable to let care staff in themselves, staff assisted people to have a keypad entry system installed. These numbers were kept secure and only given to those staff who required it. One person said: "I feel looked after and safe; they always lock the door when they leave and draw my curtains."

People had a choice of female and male care workers which was discussed with them and recorded in their care plans. One relative said their family member had requested not to have personal care from a male care worker which had been accommodated; however, the person still wanted them to visit at other times because "X is brilliant with her…X loves him."

Staff told us all the required recruitment checks were undertaken before they started work at the service. Recruitment was handled jointly between the head office and the local office. Recruitment records confirmed the necessary pre-employment checks had been completed prior to staff starting work.

People said they received their medicines safely. We spoke with staff who said they had received medicine training on their induction. The training included procedures such as how to give eye drops. Their competency was then regularly checked by the management team and recorded. Computerised medicine administration records (MAR) were completed by the management team and then sent out to people's homes to reduce the risk of error. Prior to these being sent out, people's medicines were accurately checked and the MAR amended where necessary. Care and medicine records gave staff information about what medicines care workers gave to people and when they were needed. For medicines which were given 'when required', these were monitored by the care staff and reviewed by the management team. The Provider Information Return (PIR) stated there had been five medicine errors within the last 12 months which had been recorded and investigated by the management team.

Staff said they had personal protection equipment (PPE) supplied which was readily available to reduce the risk of infection. People confirmed staff used plastic aprons and gloves when they gave care of support in their homes.

Good

Is the service effective?

Our findings

Eighty nine per cent of people who responded to our questionnaire said care staff had the skills and knowledge to deliver their care. During our visits, people said their regular core team of care staff were well trained and understood how to care and support them fully. Comments included: "They are absolutely brilliant … I have nothing but praise for them … they always ensure I get everything I need", "I'm quite satisfied … they've been very good" and "The carers are very good and very skilled."

All newly employed staff undertook a four day induction training period. The service had its own training room with equipment. An internal training team visited the service who delivered up to date training for both new staff and those already employed. No new staff started work without first completing the training. Following this, they then shadowed an experienced member of care staff (care coach) for at least 12.75 hours. Before new staff were able to work unsupervised, the care coach and the new care worker discussed their performance and competencies. A decision was then jointly made as to whether the care worker was able to work alone or required further shadowing. Staff were very positive about their training and comments included "…loads of training is provided" and "The training and supervision are excellent."

Existing staff attended training updates with the trainers when required and a computerised record of their training was held on their individual files. Management were alerted three months in advance when staff were due refresher training to ensure a training session could be scheduled into their work. If a care worker's training had expired, they were unable to work until it had been completed. A co-ordinator said " … if training is not done by the due date, work is removed from that member of staff until they have attended training which helps to ensure everyone is up to date in their knowledge and skills."

Staff were supported in their roles by a system of regular supervision meetings and yearly appraisals by the management team. Staff said these meetings provided an opportunity for them to discuss their personal development and future training requirements. The management team also monitored the standard of care delivered by care staff; this was done by making observations of staff performance in people's homes (spot checks). The computerised record system also rejected staff for visits if they had not received regular supervision and spot checks. If these were not completed, the care worker was unable to work until they had been completed.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) and to report on what we find. Staff received training on the MCA and were aware of how it applied to their practice. Staff understood decisions were made in people's best interests when they were unable to make decisions for themselves. Staff understood people were assumed to have capacity to make decisions unless it had been assessed they did not. They asked people for their consent before giving care and support and respected people's decisions to refuse care.

Records did not show which decisions people could make for themselves and which decisions needed to me made on their behalf in their 'best interests'. The provider was in the process of implementing a new format of care records at the time of our inspection. Where people had the old format of care records, mental capacity assessments were not routinely undertaken and documented. Where people had the new format of care records, people's mental capacity was recorded when this was applicable. The registered manager confirmed each person would have a mental capacity assessment in place (where it was necessary) in the next few months. This was when the new format of care records would be introduced for everyone who used the service.

People were supported to see health and social care professionals when they needed to. Care staff informed the office if they felt a person needed to see the GP or a community nurse. One family member said: "They're (care staff) very caring … they take their time and they make suggestions, for example if they think we need to get the doctor." One care worker gave an example of when they felt a person was ill and needed urgent medical help. They stayed with the person until help arrived.

People were supported to maintain a balanced diet. Staff helped by preparing meals, snacks and taking people shopping. Care staff ensured people had food and drink available within reach before they left. Records were kept of what and how much people ate and drank in the daily visit log book which was regularly monitored each month by the management team.

Good

Is the service caring?

Our findings

Staff treated people with kindness, respect and felt cared for. Ninety five per cent of people who had completed our questionnaire said they were happy with the care and support they received from the provider. Ninety four per cent said care staff were kind and caring. People we spoke with also shared positive comments about the staff and the service. These included: "They're (care staff) great and they do everything I ask exactly as I ask them to … it's a good service … excellent", "I'm very pleased with it (the service) … they always ask if I want anything else when they've finished" and "They're (care staff) all lovely people … I've had them since I came out of hospital … they wash my back …check on everything for me." A family friend said "They're brilliant … they're all good to (my friend) … nothing's too much trouble … they're all good girls." One person told us how care staff had made them feel special by taking them a turkey dinner on Christmas Day. The care worker said they "couldn't let (the person) go without."

Seventy eight per cent of people who completed our questionnaire said they received care from familiar and consistent care workers known to them. People told us they had developed caring and meaningful relationships with their regular care workers. One family member said: "It's a very, very good service … (my relative) is extremely pleased … there are four or five regulars who look after him" and one person said "They (care staff) come twice a day and they cheer me up with a bit of chat … they're all very good … we have a little natter while they do my breakfast or tea … I have the same regular ones."

People were helped to maintain their independence by care staff who encouraged them to do as much for themselves as possible. One person said: "I don't want my independence taken away." Another person said staff helped them remain independent and commented: "They are all very helpful … lots of patience … all kind and polite but without my independence it makes me lazy."

Care staff were present during some of the home visits we made. They were friendly, respectful and professional in their interaction and communication with people they provided care and support for. People said care staff always asked if they needed anything else before leaving. One person commented: "They will do anything I ask … always ensure I've got everything I need and that I don't need anything else." Another person spoke very highly of the manner of their care workers and appreciated the way in which they supported them. They commented: "They are not carers … they should be angels."

Care staff were respectful of people's privacy and maintained their dignity. People said care staff gave them privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain people's safety.

People said they were involved in making decisions about their care and support. They told us their opinions were sought about how best to care for them, were given choices and felt listened to.

Good

Is the service responsive?

Our findings

People received personalised care or support specific to their needs. Ninety four per cent of people who completed our questionnaire said they were involved in making decisions about their care or support. People we spoke with also agreed with this feedback.

Following the initial assessment and referral for care by a care co-ordinator, the field care supervisor arranged to visit the person at home. They carried out an assessment of the person's needs and developed a personalised care plan to meet their needs fully.

We visited one person whilst this assessment was being carried out. The field care supervisor completed a thorough assessment in the person's home which ensured they had all the information necessary to provide care for them. However, staff had provided care on three visits for this person without the assessment having been carried out. This meant care staff were not aware of the care required and any risks to care staff or the person had not been identified. The person told us they had advised care staff what they would like doing. They had received personal care for two of the three visits. On the third visit, the person told us the care worker had "just sat and chatted" as they did not feel up to having any personal care given. No records had been written about this visit and no communication had been made to the office about this. We discussed this with the registered manager who immediately took action to investigate the matter as Company policy stated assessments were required to be carried out within 72 hours of the person receiving care.

There were three types of care plan in place; an old one, a new one and an interim one. This was because the provider had introduced a new type of care record in April 2015; approximately 75% of care plans had been changed over to the new type. The updated care records provided a more comprehensive person centred approach to planning people's care and support needs and held much more useful and relevant information.

Care plans contained information about the care and support the person required during each visit. This included the individual's personal care needs; skin care; moving and handling; food and nutritional needs and support with medication if required. They were up to date and contained accurate information. Regular reviews were carried out on a three monthly basis or earlier if the person's needs had changed; these were a mix of face to face and telephone reviews. People confirmed they were involved in the reviews of care and were asked for their feedback about the service or if there was anything else the service could improve upon.

The provider used an 'Early Warning System'. This was a tool used by care staff to help spot the early signs of deterioration in a person's health so that timely and appropriate interventions could be requested or action taken to safeguard people from abuse, such as asking the GP or district nurse to call.

Seventy five per cent of people who completed our questionnaire said they knew who to contact if they wanted to make a complaint. The provider had a written complaints policy which was contained within the information pack given to people. People and relatives said they had no formal complaints and they were confident of speaking to the management team if they had. One person commented: "If I had problems I would speak to them … but I can't see that day ever coming." Another person said: "I'd speak to (the care co-ordinator) if I had any complaint … if I've got to go to hospital or the doctor's they'll change the time of the visit."

The registered manager had a computerised log of received complaints which were monitored at the head office. The Provider Information Return (PIR) stated there had been 8 complaints within the last 12 months which had been resolved. One family member told us they had needed to make a complaint about a care worker which they felt had been satisfactorily dealt with. 16 compliments had been received with comments including: "Wonderful devotion, dedication, compassion, kindness and loving care of all at Allied."

Requires improvement

Is the service well-led?

Our findings

There was a clear management structure in place with a registered manager in post. They had worked at the agency for 10 years, two of which were as the registered manager. They were part of a management team which included two care co-ordinators and one field care supervisor.

The care co-ordinators had a varied role which included dealing with referrals for care packages, telephone queries, scheduling visits, recruitment and staff spot checks (visits made without warning to check on a care worker's standard of care). The field care supervisor's role was to support care staff 'in the field' and carry out assessments, reviews of care and medicines, spot checks and staff supervisions. However, they also had to schedule care visits for the largest area the service covered. This meant they had to plan staff rotas for two days a week when necessary. This meant their time 'in the field' was reduced and this had impacted on their timescales to complete assessments, reviews and staff competencies. Up until recently, there had been two field care supervisors in post but due to organisational changes this had been reduced. The registered manager had acknowledged the roles of the management team had to be changed due to the loss of one member of staff. Following the inspection, the registered manager had reviewed the roles of the team's roles. They had made changes which meant the field care supervisor could now concentrate solely on their role.

We received mixed feedback from care staff about whether they felt supported and motivated in their roles. Some care staff were happy working with Allied Healthcare and their comments included: "(My relative) lives with me and I look after them; the company is very flexible and helpful if, for example, I have to take (my relative) to hospital appointments" and "We do get texts thanking us for our hard work … I get job satisfaction and you feel you mean something in the community."

However, some care staff reported morale as low with comments such as: "Support is just not great", "The company rely on our goodwill and I would never let anyone down" and "I don't feel appreciated or supported; I feel they (management) don't care." Another care worker said that following a staff meeting, care staff had been told there was a "negative culture" within the company and they felt there was "little or no positive feedback." We discussed these comments with the registered manager. They felt the lack of morale and unrest between staff was due to recent organisational changes, staff turnover and salary changes.

Care staff also worked extra hours to cover the shortfalls in staffing. The registered manager said the last six months had been particularly difficult due to several staff leaving at once but felt the situation had improved and become more settled in the last month. The registered manager was in the process of meeting with all staff to find out how the service could improve. The provider had put some processes in place to increase staff numbers and the availability of staff. For example, there was on-going recruitment for new care staff and care staff were offered 18 hour contracts as opposed to a zero hour contract. Where people's care needs were not able to be met due to a lack of staff in certain geographical areas, the provider had reduced the number of people they supported until staff recruitment was increased.

The management team also regularly worked hours in excess of their contracted hours to cover the service and undertake other roles. For example one care co-ordinator covered care calls on their way to and from work, if and when, required. The registered manager regularly worked at the office late at night due to their increased workload. The registered manager felt frustrated in their role as they wanted to improve the service delivery but felt this was not possible due to the staff shortages. The registered manager was supported by a senior manager who visited the service approximately three times a year. They also took part in a weekly telephone conference with other service managers. However, they felt the management team and the service would benefit from them receiving more support, supervision and guidance from senior management.

Reports from the computerised call monitoring system were regularly monitored and assessed as to whether care calls were being completed on time and whether care staff stayed the allocated length of time. This system also provided real time alerts in the event a call was missed or was late (more than 15 minutes) allowing office staff or out of hours staff to make alternative arrangements. However, this information was not always passed on to the local office from the out of hours team in a timely manner.

Care staff received support and advice from the management team via telephone calls, texts or face to face

Requires improvement

Is the service well-led?

meetings. Staff were able to access support and guidance from a member of the management team who were available at all times as they supported the centralised out of hours service.

Team meetings were held for all staff every three months with an agenda and ideas sought for how the quality of service could be improved. For example, reminders about good medicine record keeping. The provider recognised the value of the skills of their care staff. Each month a care worker was named 'Carer of the Month' based on the feedback from people or colleagues and received an additional payment in recognition of their hard work.

There were clear governance and quality assurance systems in place which were regularly monitored by the registered manager. These systems were computerised and flagged up when a review was due, for example people's care reviews, medication checks or staff supervisions and spot checks. Care staff completed visit log books on each visit and these were returned to the office each month. The management team checked them to ensure they had been completed appropriately and any issues addressed. Every 12 months a full audit of systems was undertaken by the Company's internal audit team; the last one took place in May 2015. Any improvements were followed up three monthly with actions plans in place which had been monitored and addressed.

Learning from incidents and accidents took place and action was taken to help protect people from harm. Incidents such as missed or late calls, concerns about people's welfare, medicine errors, were logged on an electronic database and investigated by office staff. These incidents were reviewed by the head office who regularly checked the performance of staff by reviewing these systems.

The registered manager explained that the provider was looking at how in the future they might use technology to improve the service. This included having information immediately available on people's care and support needs. For example, by using tablets to record care plans and smartphones to swipe when care workers arrive and leave a care call.

People's views and suggestions were taken into account to improve the service. For example, satisfaction surveys were sent out regularly with the last one sent out to people in April 2015 and to staff in February 2015. The responses had been analysed and any action necessary was taken. The registered manager said they discussed the results of the surveys at the staff meetings. These surveys were very complimentary of the service delivered and positive responses given to the specific questions asked. These responses included: "I am satisfied; definitely" and "I couldn't be without them." Where negative comments had been made, these had been followed up. For example, care workers were advised to ring if they were late to visits and one person requested an earlier lunch visit which was arranged.

The organisation's vision for the service was "to be the choice of care that gives people the freedom to stay in their own home". This philosophy was shared by both the management team and care workers. They worked hard to give the care and support to people who chose to stay in their own homes for as long as possible.

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 18 HSCA (RA) Regulations 2014 Staffing Suitable numbers of qualified, skilled and experienced persons were not always deployed in order to meet the needs of people using the service at all times