Care Quality Commission

Burlington Care Limited

Burlington Home Care

Inspection report

Lancaster House
Lancaster Road
Carnaby
Bridlington
East Yorkshire
YO15 3QY
Tel: 01262 609865
Website: www.burlingtoncare.com

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Ratings

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

Overall summary

This inspection took place on 2 and 4 November 2015 and was announced. This was the first inspection since the service had moved into new premises and been registered as a separate domiciliary care agency.

The service is registered to provide personal care. The agency employs approximately 40 care workers who provide support to people living in their own homes, such as washing, dressing, assisting with the administration of medication and the preparation of meals. The agency office is located in Carnaby, close to the town of Bridlington, in the East Riding of Yorkshire. Staff provide a service to people who live in Bridlington and other areas of the East Riding of Yorkshire. There is car parking available at the premises.

The registered provider is required to have a registered manager in post and on the day of the inspection the manager was not registered with the Care Quality Commission (CQC). However, they had started the

Summary of findings

registration process. 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 told us that they felt safe whilst they were receiving a service from staff working for Burlington Home Care. People were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding concerns. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records evidenced that all staff had completed induction training and that all staff had completed training on the topics considered to be essential by the registered provider. Some staff had also achieved a National Vocational Qualification (NVQ).

New staff had been employed following the agency's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people had been employed. We saw that there were sufficient numbers of staff employed to meet people's individual needs.

People told us that staff were caring and that their privacy and dignity was maintained.

People told us that they received the support they required from staff and that their care packages were reviewed and updated as required. They expressed satisfaction with the assistance they received with the administration of medication and meal preparation.

There were systems in place to seek feedback from people who used the service and staff. Feedback had been analysed to identify any improvements that needed to be made. We saw that, on occasions, feedback that had been received had been used as a learning opportunity for staff.

Complaints received by the agency had been investigated appropriately. People told us they were confident that if they expressed concerns or complaints they would be dealt with appropriately.

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 safe.

Risk assessments protected people who received a service and staff from the risk of harm. Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they had any concerns.

Recruitment practices were robust and ensured only those people considered suitable to work with vulnerable people were employed. There were sufficient numbers of staff employed to meet people's assessed needs.

People told us that they were satisfied with the assistance they received with the administration of medication.

Good

Is the service effective?
The service was effective.

Records showed that staff completed training that equipped them with the

skills they needed to carry out their role.

People told us that their nutritional needs were assessed and that they were happy with the support they received with meal preparation.

Good

Is the service caring?
The service was caring.

People told us that care workers genuinely cared about them and that their privacy and dignity was respected. Staff understood the importance of confidentiality.

There was information available for people about advocacy services should they need this support.

Staff supported people to be as independent as possible.

Good

Is the service responsive?
The service was responsive to people's needs.

People's needs were assessed and continually reviewed and this meant that

staff were able to meet their individual care and support needs.

People's individual preferences and wishes for care were recorded and these were known and followed by staff.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Good

Is the service well-led?
The service was well-led.

Good

Summary of findings

There was a new manager in post who had started the registration process with CQC. People who used the service and others told us that the service was well managed

People expressed satisfaction with the consistency of the service but said they would like to be informed when a different care worker would be attending.

There were opportunities for people who used the service and staff to express their views about the service that was provided by the agency. There was evidence that people's feedback was listened to and acted on.

Burlington Home Care

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.

The inspection took place on 2 November 2015 and telephone calls to people who received a service took place on 4 November 2015. The inspection was carried out by two inspectors and was announced; the registered provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office to assist us with the inspection.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority (including two social care professionals) who commissioned a service from the agency. The provider was not asked to submit a provider information return (PIR) prior to the inspection on this occasion; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who use the service.

On the day of the inspection we spoke with the registered providers, the manager, a care coordinator, two members of staff and an administrator. Following the inspection we telephoned nine people who used the service from the agency to ask them for their opinion about the service and spoke with five members of staff.

At the agency office we spent time looking at records, which included the care records for three people who received a service from the agency, the recruitment and training records for two members of staff and other records relating to the management of the agency.

Good

Is the service safe?

Our findings

People told us that they felt safe whilst care workers were in their home. One person told us, "Yes, safer than when I am on my own" and another said, "Yes, definitely. I've never had any concerns."

We checked the care plans for three people who used the service and saw they all contained a risk and safety assessment that recorded the safety of the person's home environment and any risks associated with the person's care. This included an assessment of the assistance the person required to mobilise, any continence needs, medication needs, nutritional needs and behaviours that might challenge the service.

Care plans described how people mobilised, identified equipment that was needed to safely assist people with moving and handling, and also recorded whether one or two care workers were required to carry out these tasks safely. We noted that moving and handling risk assessments recorded whether hoists and slings were used, and included a 'traffic light' system to determine the person's severity of risk / need and the control measures in place to reduce any identified risks.

The training record we saw evidenced that all staff had completed training on moving and handling, although the refresher training for four staff was overdue. We saw that this had been booked for 16 November 2015. In addition to this, all staff had attended the optional training provided by the agency on falls awareness. This meant that staff had the knowledge they needed to assist people to mobilise safely and minimise the risk of falling.

Staff had attended training on safeguarding adults from abuse. One member of staff told us they had completed this training as part of their induction training and that they were "Not allowed out on their own" until they had completed this training. The care workers who we spoke with were clear about the action they would take if they observed an incident of abuse or became aware of an allegation of abuse. They told us that they would ring the office to speak to the manager or one of the senior staff, and that they were certain the information would be dealt effectively. The agency had a policy on safeguarding vulnerable adults from abuse and the documentation we saw in the agency office evidenced that safeguarding alerts were submitted to the local authority as required.

Care workers told us that they would use the agency's whistle blowing policy if needed and they were confident that this information would be handled confidentially. One member of staff told us that they had reported information to office staff using this policy and their concerns had been dealt with properly.

There had only been one reported accident since the agency was registered in December 2014. This had been recorded in the agency's accident book and logged on the database. Because there had only been one accident there had been no need so far to audit or analyse accidents and incidents to identify any improvements that needed to be made.

We saw that there was an effective 'on call' system for outside of normal office hours. This included information for the staff member on duty about how to deal with emergencies, cancel any calls that were not needed and restart services for people. People who we spoke with told us that they had not had any problems contacting office staff; they told us that they rang the usual number and were put through to the staff member on call.

We checked the recruitment records for two new care workers. We saw that an application form had been completed that recorded the person's employment history and the names of two employment referees. People completed a medical questionnaire to show they were fit to carry out the role of care worker and provided documents to confirm their identity; these had been retained with personnel records. Two written references and a Disclosure and Barring Service (DBS) first check and full check had been obtained by the registered provider. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

It was not clear from the records held whether new care workers had started to work unsupervised before safety checks had been received by the agency office. The manager assured us that, although care workers completed induction training and shadowed experienced staff whilst they were waiting for these safety checks to be completed, care staff did not work unsupervised in the community until their fitness to be employed had been verified. This was confirmed by the care workers who we spoke with.

Good

Is the service safe?

The agency employed approximately 40 care workers. The feedback we received from people who used the service and care workers indicated that there were sufficient numbers of staff employed to meet the needs of the people who were currently using the service. A senior member of staff explained to us how they allocated tasks to these workers to reduce the amount of travelling time and to promote consistency for people who used the service. Care workers told us that they were allocated enough time to meet each person's needs and that they always stayed at the person's home for the agreed length of time. One care worker told us, "If we think a person needs more time, we contact the office and they try to arrange it." Another care worker told us that some people who used the service had recently had their allocated time increased so that care workers had enough time to meet people's needs.

However, two people who used the service told us that although things had improved, the agency still seemed to be understaffed and 'had a job' to cover calls, although they always managed to. Agency office staff told us that they addressed this by turning down new requests for support if they did not have sufficient numbers of staff in that particular area to meet the person's needs.

The people who we spoke with who had assistance to take their medication told us that their medication was administered on time and that there had never been any errors. One person told us that they had not been taking their medication correctly but "Things were much better now staff are administering medication." We saw completed medication records in care plans and noted that they had been completed correctly and that there were no gaps in recording. This evidenced that people had received their medication as prescribed.

The manager told us that care workers were not allowed to administer medication until they had completed medication training. The care workers who we spoke with confirmed this. The topic of medication was included in induction training and records showed that all care workers apart from four had completed further training. These four members of staff were booked on medication training. In addition to this, the minutes of the staff meeting on 17 September 2015 evidenced that all staff were given a copy of the agency's medication policy. They were asked to read the policy and contact the manager for clarification if they had any queries.

There was a contingency plan in place that advised staff about the emergency procedures to follow in the event of adverse weather conditions, a fire or a power / water supply failure, and how to prioritise work schedules should an emergency situation arise. The contingency plan included information about staff safety and also advice for care workers on how to keep people who live in their own homes safe, such as checking room temperatures to reduce the risk of hypothermia.

Good

Is the service effective?

Our findings

The people who we spoke with told us that staff had the skills to 'do the job'. One person told us about the training a group of care workers had attended that was needed to meet their specific needs. Care workers told us that they were happy with the training they received from the agency. However, one social care professional told us that they had received feedback that some new care workers required training in ironing and cooking. This was fed back to the manager.

The training matrix identified training that the agency considered to be essential, and training that was optional. Essential training consisted of homecare induction training, fire safety, moving and handling, infection control, safeguarding awareness, dementia awareness, health and safety, basic life support or first aid and medication. There were a small number of gaps but the matrix recorded that training was booked to ensure the training for these members of staff would be brought up to date.

Optional training included falls awareness, privacy and dignity, equality and diversity, person-centred care, communication / customer care, the control of substances hazardous to health (COSHH) and food hygiene. We saw that most members of staff had also completed this training.

Some staff had completed National Vocational Qualifications (NVQs. This showed that the agency supported staff to develop their skills and knowledge.

When staff had completed training at previous workplaces, they were asked to provide copies of those training certificates to evidence their level of competency. However, they were still expected to complete the organisation's induction training. The agency's induction training covered the topics the registered provider considered to be essential training. The care workers we spoke with also confirmed that they shadowed experienced staff as part of their induction training.

We saw that when care workers were new in post they had probationary meetings so that their progress could be monitored and that any additional training needs could be identified.

The manager told us that they were aiming for staff to attend a supervision meeting every three months, an annual appraisal meeting, four staff meetings a year, have observations whilst working twice a year and medication competency checks twice a year. The records we saw evidenced that all staff had attended a supervision meeting and a staff meeting during 2015

Care workers told us that they were happy with the support they received from the manager and other senior staff. One care worker told us, "I am out on my own but there is always someone on the end of a telephone" and another care worker told us they had not been well and the support they had received from agency staff was "Brilliant." Staff told us that supervision and staff meetings were a 'two way' process; they received information from managers but were encouraged to express their views and discuss any concerns.

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.

We checked whether the service was working within the principles of the MCA and found that two care workers and the manager had attended training on the MCA and eight care workers were due to attend this training in February 2016; the training was going to be provided by the organisations in-house training team. Care plans recorded a person's capacity to make decisions. We saw that most people had signed to record that they agreed to the content of their care plan.

Care workers told us that they helped people to make decisions and choices; they gave us examples of how they showed people different clothes so that they could make a choice and how they offered people a variety of meal choices.

We saw that, when meals were prepared by care workers, they recorded this information in daily records so that other care workers could see what meals had been provided previously and relatives were able to check that people were receiving meals that met their nutritional needs.

We saw that care plans recorded a person's nutritional needs; this included their likes and dislikes as well as any special dietary requirements. One person's care plan that

Good

Is the service effective?

we saw had recently been rewritten to record that they required Stage 1 thickened fluids to reduce the risk of choking. This had been decided following an assessment by a speech and language therapist (SALT) and a risk assessment in respect of aspiration. Two people told us that they had special dietary needs and that all care workers who visited them were aware of this and they had never had any concerns about the meals provided. This showed us that there was a system in place to support people to eat and drink enough and maintain a balanced diet.

Staff told us that they also spoke with people to make sure they were providing meals that they enjoyed as well as meeting their nutritional needs. One member of staff told us that they took meals from the freezer to show to the person so that they were able to choose the meal they wanted.

Information about each person's physical and emotional health needs were recorded in their care plan. One person's care plan recorded that they had been found to be unwell when a care worker had arrived at their home. The care worker had contacted the person's relative and then the emergency services to ensure the person received medical attention. We also saw contact that had been made with GPs when care staff had concerns about a person's general health.

We asked the manager how information was shared with staff. For example, if an incident had occurred at someone's home, how staff involved in the person's care package were informed. They told us that all staff would get an individual telephone call from agency staff to share this information with them, and staff told us that they also received a memo. from the office to inform them if a person's social or health care needs had changed. The manager said that, within seven days, the person's care plan would be updated and the new care plan would be taken to the person's home to replace the out of date version.

The two health care professionals who gave us feedback told us that the agency communicated well with them. One person said the agency "Kept in regular contact with any updates or concerns." This meant that professionals involved in the person's care received relevant information to ensure they were aware of current care needs.

Good

Is the service caring?

Our findings

The agency's service user guide recorded that they had signed up to the 'Dignity Challenge' and that the manager was running a Dignity campaign with the staff team to highlight the importance of respecting one another. The 'Dignity Challenge' describes values and actions that high quality services should follow to ensure people's dignity is respected. .

We asked people if their privacy and dignity was respected and several people said, "Definitely – my privacy and dignity is always respected." Care workers described to us how they respected a person's privacy and dignity, especially when they were assisting them with personal care. They told us that they made sure they closed curtains and closed doors and that they talked to people throughout the process, checking that they were happy with the support being provided.

We saw that training on privacy and dignity was included in the list of optional training for staff, and that most staff had completed this training during the last two to three years. All staff had also completed training on equality and diversity, communication and customer care, and person centred care. All of these topics helped staff to understand the importance of treating people with respect, privacy and dignity.

Everyone who we spoke with told us that staff cared about them. Comments included, "Definitely – they are fantastic staff – I would highly recommend them", "I do, every single one of them", "They go over and above" and "Some maybe more than others – maybe because I have known them for longer. But I don't have concerns about any of them." The care workers who we spoke with agreed. One care worker said, "Yes – all the ones I work with are great" and another told us, "Yes, we have a good team at the minute."

We also spoke with the relative of one person who received a service from the agency. They told us that their relative had recently been discharged from hospital and they specifically requested that the home care service be provided by Burlington Home Care. They said this was because of the quality of the staff they employed as "They really seem to care." A health care professional told us, "Carers are very supportive and flexible and understand medical conditions of service users."

People told us that care workers recorded information in their care plan at each visit to ensure that all staff were aware of their current care needs. One person told us, "Staff record in it each day and take it to the office when it is full so that it can be audited." The manager told us that daily record sheets were returned to the office periodically so that they could be checked. This enabled agency staff to check that recording was respectful and accurate, and that any concerns identified by care workers had been passed to the agency office.

We asked care workers if they encouraged people to do as much as they could for themselves to retain their independence. They all told us that they did. Comments included "Yes, that is why they live at home, because they want to retain their independence", "We take people shopping if they can go rather than doing it for them" and "If they can shower themselves, I would encourage them to do so."

Care workers told us that they were told about the importance of confidentiality during their induction training and that they were always alert to this in their day to day work. They were also confident that if they shared any information under the whistle blowing policy with the manager or registered provider, or any other information they considered to be private, it would remain confidential. None of the people who we spoke with expressed concerns about confidentiality and no complaints or concerns had been received by agency staff. The minutes of the staff meeting in September recorded that confidentiality had been discussed and staff were praised for their vigilance.

On the day of the inspection we noted that there was no information available about advocacy for people who received a service from the agency. Advocacy seeks to ensure that people, particularly those who are most vulnerable in society, are able to have their voice heard on issues that are important to them. We discussed this with the manager and they assured us that this information would be added into the service user guide. The following day the manager sent us an updated copy of the service user guide that included information about advocacy, including contact details for various organisations that would help put people in touch with an advocate and information about Independent Mental Capacity Advocates (IMCAs). IMCA's provide an advocacy service for people who do not have the capacity to make decisions for themselves

Good

Is the service caring?

and have no-one else to represent them. The updated service user guide provided useful information for people who used the service and enabled them to contact advocacy services for advice independently.

The only concern raised by people who used the service was that they did not always receive a telephone call if there had been an emergency and a different care worker would be visiting them, although people told us they did receive a telephone call if the care worker was going to be late. However, people did say that the replacement care worker was usually someone who they knew. We discussed this with the manager who told us they made every effort to contact people but that there might be occasions over the weekend when this was not as effective as it should be.

Good

Is the service responsive?

Our findings

Care plans recorded information that had been shared with people when they first started to receive a service from the agency; this was in the form of a checklist and recorded when people had received a copy of the service user guide and complaints procedure, and that the review process had been explained to them.

The care needs assessment was based on information gathered from the person themselves and from the support plan provided by the local authority that commissioned the service (when they funded the care package or were involved in the person's care). The assessment included information about any allergies the person had, and the person's likes, dislikes and dietary requirements.

We found care plans to be person centred. The care plan recorded the tasks that needed to be completed at each visit from staff. One area the care plan covered was daily living; this described the person's routines, personality traits, people who were important to them, their previous employment and what they were able to do for themselves. Other care plan areas were mobility, eating and drinking, medication and pain management, skin care and pressure relief, capacity and consent, mental health and memory, and end of life care. All care plan areas recorded the specific care need, the expected outcome or goal and the support and care to be provided to achieve these goals. This meant that staff had information that helped them to get to know the person and meet their individual needs.

We saw that care plans recorded details of each visit people required from care workers. We noted that one person had commented at a care plan review that they required four hours between staff visits due to their medication needs. At the time they raised this concern records showed that there was not always four hours between calls. We checked more recent records and saw that there were four hours between calls. This showed that the person had been listened to and their individual needs met.

We observed some handwritten entries on people's care plans to record their changing needs. These included changes to a person's mobility needs, dietary requirements and assistance needed with personal care. One person had been referred to speech and language therapy services (SALT) following a care plan review and agency staff had completed an assessment on the risk of choking. The care plan identified this person's changing needs. Another person told us that their care package had been reviewed a few weeks ago as their physical health needs had changed; their care plan had been changed to reflect this.

People who we spoke with told us that care workers usually arrived on time; some people said that they were occasionally five minutes late but no more. One person told us that care workers sometimes stayed for five minutes longer than their allocated time. No-one that we spoke with had experienced a 'missed' call. This meant that people were receiving the level of service that had been agreed with them.

The statement of purpose and service user guide included information about the agency's complaints procedure. Each person received a copy of these documents when they started to receive a service from the agency. We saw that the service user guide included a comments slip that could be used to submit concerns, compliments, suggestions or requests to the agency office. The contact details for CQC were included in the complaints information so that people could share information with us if they chose to.

We checked the complaints log. This contained a form that was used to record details of the complaint and the investigation that was carried out by agency office staff. The manager told us that the same form would be used to record accidents and incidents as these would be treated as complaints from the point of view of any learning to be identified. We saw the records for a recent complaint and these evidenced that an investigation was carried out by the manager and a meeting was arranged with the person concerned and their family so that the issue could be discussed further. We saw that other complaints recorded in the log had been fully investigated and responded to.

People who used the service told us that they knew how to make a complaint and gave us the name of the person in the agency office who they would speak to. One person said, "I cannot speak highly enough of (name)." They told us that, when they had contacted the agency office to discuss concerns, these were listened to and acted on. Staff told us that they would support people to make a complaint if they were reluctant to do so.

Good

Is the service responsive?

One person told us that they had recorded in a satisfaction survey that they were not keen on two of the care workers who visited them, and they never visited them again. This showed that people's concerns were listened to and acted on.

Good

Is the service well-led?

Our findings

As a condition of their registration, the service is required to have a registered manager in post. The previous registered manager had left the service and a new manager had been appointed; they had started the registration process with the Care Quality Commission (CQC) three weeks before this inspection.

Services that provide health and social care to people are required to inform the CQC of important events that happen in the service. The manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We asked care workers if they thought the agency was well managed. The comments we received included, "Fantastic compared to previous jobs", "Very friendly and they listen", "If you're stuck they will help you", "Excellent – more organised", "More support has been provided for staff" and "The manager and the seniors are very good." People who received a service also told us they felt the agency was well managed. One person described to us how they needed some mobility equipment and were told there was a waiting list; one of the agency staff had followed this up and they received the equipment the next morning. They felt this showed that agency office staff listened to their needs and made efforts to provide optimum care.

A social care professional told us, "The service is very flexible if required and at times goes above and beyond what is expected of them" and another said, "At reviews some service users are delighted with the care given to meet their needs."

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely. We saw that medication records and daily diary records were periodically returned to the agency office; this allowed agency staff to check these records for accuracy and identify any staff training needs. We checked a sample of the medication records and daily diary records. The daily diary records showed that staff recorded the time they arrived at a person's home and the time they left. They recorded the tasks they had completed at every visit, including details of the meals and drinks they had prepared. When two staff had visited together, both staff had signed these records.

The registered provider encouraged open communication via the use of quarterly surveys; we noted that these were also available as an 'easy read' version to make them more accessible to people who used the service. We checked the responses in the most recent survey. One service user stated they were, "Comfortable with the carers who come in" and "I like the fact that only two carers visit during the week." They added that this put them at ease when they were assisted with personal care. Feedback was evaluated in a "You said, We did" action plan. An example provided under the heading "You Said" was "Care staff don't always arrive on time" and the provider responded under the heading "We did" with "We have made steps to improve rota patterns and recruited more care staff." This showed how feedback from people who used the service was actively used in developing the service. The registered provider advised that further summary and evaluation of the questionnaires was in progress to provide comparative data on an annual basis.

Records showed that staff attended quarterly team meetings. Minutes of the meeting held in September 2015 evidenced that information was shared between managers and staff on the key challenges, achievements, concerns and risks within the organisation. This included updates on policies and procedures, staff training, operational issues and reporting concerns. We noted that one section of the meeting addressed "What can we do better?" where the registered provider and manager discussed concerns raised and actions taken to ensure service improvement. When staff were unable to attend a team meeting the minutes were emailed to them. This meant that all staff were aware of the discussions held and decisions made at team meetings.

A 'staff opinion survey' was also distributed to staff and we noted that this allowed employees to question the strengths and weaknesses of the registered provider and help to shape the future of the service.

We saw that there was an annual programme of audits in place. This included an analysis of missed calls, induction training, staff files, surveys and the medication recording system. The staff file audit on 26 October 2015 highlighted that one member of staff had not attended an appraisal meeting. Another audit identified that staff were not always using black ink to record in people's care records. All of the audits we saw included an action plan to address any identified shortfalls. For example, there was an action plan

Good

Is the service well-led?

in place to record that a memo. had been sent to care staff to remind them they must always use black ink to record in care plans. The most recent audit undertaken by the manager showed improvements in checks made against medication, care plans, quality and compliance, staff training and induction and staff personnel files.

The service did not have any written visions and values in respect of their culture, but there was a statement of purpose and a service user guide in place. These were given to all new users of the service. The statement of purpose included details of the agency's aims and objectives, their care principles, the staff structure, the rights and expectations of service users and information about health and safety. The service user guide included a mission statement and clear information about what people could expect from the agency, such as "Making sure you have choice and control over your life and that you are as involved as possible in all aspects of your daily life" and "Making sure your lifestyle is, as far as is possible, one you would choose for yourself so that your social, cultural, religious and recreational needs are met."

We asked care workers about the culture of the service. Their comments included, "Very friendly and supportive", "Open and honest", "I feel confident that if I raise an issue it will be dealt with", "We respect each other" and "We are more like a family."

We discussed rota management with agency office staff and checked the relevant records at the agency office. They told us that they allowed some travelling time for staff in between visits so that staff did not have to rush from person to person. They also said that they tried to "Keep runs together" so that there was only two to three miles between visits, and that this helped staff to be able to get to each person on time.

Most care workers told us that they received enough travelling time in between calls so they did not have to rush from person to person, and never had to 'cut short' visits so they could arrive at their next visit on time. One care worker told us that the senior care worker had done some of the 'rounds' so that they knew how much time it took to get from visit to visit. Another care worker told us that agency staff were trying to condense 'runs' to reduce travelling time but that there were still occasions when they had to rush from visit to visit.

Any visits that required two care workers to work together were incorporated into both staff rotas and agency staff told us that they used regular staff to 'double up'. In addition to this, if a person required a member of staff to visit them four times a day, one member of staff would carry out the morning and lunchtime calls and another would carry out the teatime and evening calls. These arrangements reduced the number of different staff involved in the person's care package and helped to provide a consistent service.

People who received a service told us that they were supported by a consistent group of staff and that this only changed if staff were on annual leave or sick. One person told us they received support from two care workers four times a day and that this was provided by a group of four care workers. Another person told us that they knew their regular care worker was going to be absent and they had already been told who would be visiting them instead.

Some people received a timetable each week to inform them who would be visiting each day. We saw in the minutes of a meeting in September 2015 that the manager had said this was not acceptable, and that everyone who received a service would be sent a weekly timetable in future.

The agency did not have a system in place to manage missed calls. They relied on people contacting the office to report that staff had not arrived as expected, or for staff to contact the agency office when this had come to their attention. We discussed this with the registered provider and they told us that they were in the process of considering a variety of options to provide a more robust call monitoring system.