New Care (Devon) Limited

New Care (Exeter)

Inspection report

6 Sandpiper Court,
Harrington Lane, Exeter,
EX4 8NS
Tel: 01392 460046
Website: www.www.newcaredevon.co.uk

Date of inspection visit: 12, 16 and 23 March 2015
Date of publication: 13/05/2015

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?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Overall summary

This inspection took place on 12, 16 and 23 March 2015 and was announced. We had previously inspected the service in August 2014 because of concerns about the service and found breaches of regulations regarding people's care and welfare and staffing. This was because the service did not have sufficient staff which resulted in late and missed visits.

Newcare Exeter is a domiciliary care agency that provides personal care and support for people in their own homes, including people living with dementia, and with care needs and physical disabilities. At the time of our visit, they agency provided care for 105 people in their own home and employed 46 care staff.

The service is required to have a registered manager, the previous registered manager left at the end of 2014 and was replaced by a manager who was already working at the service. The manager has not yet registered with the Care Quality Commission but said they plan to do so. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

At this inspection we found some improvements had been made. The branch manager reported they had recruited enough staff to meet people's needs and there were very few cancelled visits, all of which were discussed and agreed in advance. However, high levels of staff sickness meant people still reported having some late visits and lots of different care workers visiting them, particularly in the evenings and at weekends.Further improvements were needed in staffing to ensure there were sufficient numbers of suitable staff at all times to meet people's health and welfare needs.

People reported very variable experiences of communication with the agency's Exeter office, with rotas often being sent out late, which were often incomplete and with messages sometimes not being passed on. Staff also reported difficulties with communication in the office and late and incomplete rotas. Further improvements were needed in systems to ensure better organisation of the service and improved communication between people, care workers and office based staff. Although complaints received were thoroughly investigated, and dealt with there was a recurrence of similar themes because of underlying staffing and system issues that needed to be further improved.

Most people were happy with the care provided by staff who visited them and said they were treated with dignity and respect. People's comments included, "I am very happy, they look after me very well" and "They are very kind to me and I have no real problems".

People's care and health needs were assessed and care plans included detailed information for staff about people's care needs. These were reviewed and updated regularly as people's care needs changed.

A robust recruitment process was in place to make sure people were cared for by suitable staff. Staff were aware of signs of abuse and knew how to report concerns and were confident these would be investigated. Improvements had been made in medicines management to ensure people received their prescribed medicines on time and in a safe way. The provider had increased the monitoring of care workers through regular spot checks and people 's care records were regularly updated as their care needs changed.

The agency had comprehensive staff training and carried out regular appraisal and supervision with staff and supported them with their professional development. There were good quality monitoring systems in place and the provider was aware of the areas for improvement we found and were taking further steps to improve them.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. Throughout the report we have explained how these correspond to the regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 which came into force on 1 April 2015. You can see what action we told the provider to take at the back of the full version of this report

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

People who used the service were safe most of the time. Although staffing levels had improved from our last visit, further improvements were still needed to ensure there were sufficient numbers of suitable staff at all times to meet people's needs.

People told us they felt safe, and felt well supported by staff who visited them. The provider had arrangements in place to protect people from avoidable harm. Staff could recognise signs of abuse and were confident the provider took appropriate action whenever they raised any concerns.

Risk assessments were carried out on each person and care plans included ways to reduce risks as much as possible. People were protected because of robust recruitment procedures and safe medicines management systems

Is the service effective?

Good

The service was effective. People's healthcare needs were assessed and care plans included detailed instruction about how to meet individual needs. People were referred to healthcare professionals appropriately and staff followed advice given.

The service was meeting the requirements of The Mental Capacity Act for people who lacked capacity.

There was a comprehensive staff training programme relevant to the care and health needs of people the agency supported. Staff received regular supervision and spot checks and had an appraisal during which their further training and development needs were discussed.

Is the service caring?

Good

The service was caring. People were supported by staff that were compassionate and treated people with dignity and respect.

People were involved in planning and making decisions about their care.

Is the service responsive?

Requires Improvement

The service wasn't always responsive to addressing people's concerns. People knew how to raise concerns and make complaints but these were not always addressed to their satisfaction because the problems they complained about often recurred.

Each person had a personalised and detailed assessment of their care and support needs, which were reviewed and updated regularly as their needs changed. Staff were knowledgeable about the needs of each person and people were generally very satisfied with their care.

Summary of findings

Is the service well-led?

The service was not always well led. Although the service had improved, some aspects of the provider's systems were not fully effective. Weekly rotas outlining planned visits by care staff were often late and incomplete. Office based staff spent a large proportion of their time covering gaps in rotas because of staff sickness. People and staff reported difficulties and delays with communication.

There were a range of quality monitoring systems in place and findings were regularly reported to the provider. The provider was aware of some problems and efforts were underway to improve office based systems to make them more efficient and effective.

Requires Improvement

New Care (Exeter)

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 on 12, 16 and 23 March 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to arrange to visit some people that used the service.

The inspection team consisted of an inspector, pharmacist and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. Before the inspection we looked at all the information we held about the service including all notifications sent by the provider.

We spoke with 43 people in total, which included people using the service, their relatives and a friend. We looked at 17 care records which included medication records for 12 people. We interviewed 17 staff, which included a director in the company, the branch manager, care workers and office based staff such as care co-ordinators, field care supervisors and staff trainers. We contacted commissioners, social workers, GP surgeries and therapists and received feedback from three of them.

Requires Improvement

Is the service safe?

Our findings

People reported they felt safe being care for by the staff that visited them. A number of people reported they had one or two regular care workers they had got to know and trust. However, many of the people and relatives we spoke with also reported they had a lot of different care staff visiting them, particularly at evenings and weekends. For example, one person had a regular care worker five days a week but said evening staff were not so good and they never knew who would visit them at weekends and bank holidays. This theme was echoed by many other people and relatives we spoke with. One relative said, "It would be really nice to see the same two carers each weekend as it's hard for her to adjust to different ones". Another person said, "I have different carers every day, it's terrible. There were nine last week."

Some people reported improvements in staffing since we last visited. One person said, "I must say there has been some improvement and I think they are trying to get some continuity and consistency, it's just a bit disorganised". Another said, "If you'd asked me six months ago, I'd be more damning but recently, a definite improvement". A third person also commented that they had seen some improvement in the past few months.

People said staff stayed for the time they were supposed to but they were often late particularly in the evening and at weekends. One person said, "I know they have staffing problems but it always seems to be an issue on Fridays". Another said, "They do seem to struggle with staff at the weekend". One person said, "I usually have someone here at 7.20 pm but last Friday it was 9.30pm and I was getting rather worked up". Another said, "Being diabetic, I like them to be here around four o'clock but more often than not it's five, which is not good for me".

People and staff reported high levels of staff sickness contributing to lower staffing levels particularly at weekends. One staff member said, "There seems to be a lack of staff with illness and holidays, but I have been here for the last 10 years so it's not all bad". Another said, "They get into a pickle working out the rotas, there seems to be a lack of staff with illness and holidays".

We followed up with the branch manager how staffing levels were assessed and monitored to make sure they were flexible and sufficient to meet people's individual needs and to keep them safe. The manager confirmed the agency had further reduced the amount of care packages they provided and were currently providing just over 1,400 hours of care each week. They said currently, their staff calculations showed there were enough staff employed at the agency to meet the needs of people the agency was caring for. However, difficulties with short and long term staff sickness, was having an impact on their ability to provide continuity of care workers for people. They also reported recruiting new staff was difficult, particularly to work more evenings and weekends. The provider had introduced incentives to try and improve recruitment such as a reward for existing staff who referred a relative or friend to work for the agency and paying for applicant's criminal record checks. The manager confirmed no further clients would be accepted at the branch until they had recruited more staff.

Some staff told us previously, the agency had some flexible staff to cover sickness and several said they had suggested this but so far it hadn't happened. We asked the manager about this and they said the staff who had previously worked flexibly in this way had now left and they hadn't been able to replace them. This meant the agency was reliant on existing staff doing extra hours to provide cover for sickness and staff holidays. Staff feedback was that they were under pressure to work longer hours/overtime to cover especially at weekends and evenings which often led to late visits or increased sick leave. One staff said, "There seems to be a lot of staff off sick all the time and management try and put extras on to you". Several other staff reported similar experiences.

The manager said field care supervisors (office based staff that assessed people's care needs and monitored staff practice) and they themselves sometimes undertook visits, when needed. However, this contingency could only be used with the agreement of senior managers in the company, as it impacted on their ability to carry out their role at the branch. We found those staff had carried out some care visits during the period of the inspection.

The agency used a system for prioritising visits to ensure people's safety in the event of staff shortages. This identified the most vulnerable, such as those who were totally reliant on two care workers visiting them for their daily needs or needed a visit at a specific time because of

Is the service safe?

their medication or for regular food and drink and these visits were prioritised. This meant some, less urgent visits were changed to a later time or to a different day or were cancelled with people and relatives agreement.

We concluded that although staffing levels had improved from our last visit, people were not fully protected by having sufficient numbers of suitable staff at all times to meet people's health and welfare needs.

This was in breach of regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People were protected because the provider had robust recruitment procedures to assure them about the fitness of applicants. All staff were interviewed, references sought and appropriate background checks made to confirm they were suitable to work with people. The manager outlined the recently improved recruitment procedures through assessing applicant's skills and values to check their suitability to work in care. They said this had resulted in better retention of the staff recruited. One relative also commented on this, they said, "They are making a concerted effort to take on more experienced people".

People said they felt safe with the team of staff who visited to support them. They were robust security arrangements so people could be confident in their own home. For example, some people had a key safe fitted to ensure care workers could securely access their home. People were sent rotas telling them which staff would be visiting and what time. All staff wore uniforms and carried photographic identification so people could confirm their identity. People knew how to contact the office and said they could ring if they had any concerns.

Before commencing care, the agency undertook comprehensive risks assessments for each person, which identified individual risks, and how to support and reduce them for each individual. For example, they identified people at risk of falling, skin damage, any moving and handling risks or environmental risks in people's individual homes. Staff had comprehensive information about how to support people to reduce risks and how to support the person to move safely around their home and maintain their independence as much as possible. For example, detailed moving and handling plans about how to help the person get out of bed or get into the bath or shower as well as how to use any equipment needed. Staff were trained to use moving and handling equipment such as hoists and slings and community occupational therapists and physiotherapists confirmed agency staff followed any specific instructions provided.

People confirmed staff washed their hands before and after providing care and wore aprons and gloves, when providing personal care to reduce the risk of cross infection. Accident/incidents were reported and reviewed to identify any action needed to reduce the risks of recurrence. Information about any risks identified were reported on regularly to the agency so that they could be monitored to identify any themes or trends.

Staff were knowledgeable about how to recognise signs of potential abuse and were confident any concerns raised with senior staff would be dealt with. Any concerns about suspected abuse were reported to the local authority safeguarding team and notified to the Care Quality Commission and appropriate actions taken to reduce risks. The agency also had policies and procedures for staff to follow and encouraged and supported staff to raise any concerns in confidence.

People received their medicines in the way prescribed for them. Medicines risk assessments were completed for each person and medication charts were generally well completed by staff, including the application of creams or other external medicines. The medication charts were produced in the office and checked by senior staff, and any alterations or additions could only be made by senior staff. Any alterations made were clearly recorded, signed and dated. Any changes in people's medicines were dealt with quickly to make sure they were no delays in people receiving them.

The manager outlined improvements made to medicines management since we last visited. This included new documentation, updated policies and procedures and an improved training programme. Training included safe medicines handling and administration. Each staff member had to undergo a competency assessment before they could administer or prompt people with their medicines. Staff had detailed guidance on managing people's medicines. The manager reported improvements in

Requires Improvement

Is the service safe?

standard of records of medicines given, which we confirmed from the records we looked at. All medicines records were audited and any problems were identified and addressed with individual staff.

People who were supported with medicines were positive about the service they received. One said, “They put the tablets on the table for me and I take them in front of them”, another said, “the carers give me my medication, and sign the forms”. Some staff also supported people by collecting their medicines regularly for them from the pharmacy.

Good

Is the service effective?

Our findings

People reported most of the care staff were polite, friendly and were professional in their appearance and were well trained for the role. The agency employed three field care supervisors who did a full assessment of people's individual health needs at the beginning of any package of care. This included the use of evidence based assessment tools for assessing people's nutritional needs, moving and handling needs and any specific skin care needs. From this assessment, a detailed care plan was developed so that staff had clear instructions about what care was needed at each visits.

Staff had received training in understanding the Mental Capacity Act 2005. The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. As part of the initial assessment, each person's mental capacity to consent to care or treatment was recorded. Where people lacked capacity, the records identified other people who could help with decision making such as relatives, people with power of attorney and health professionals. When we asked staff about how they cared for people who lacked capacity, they demonstrated how they supported people to make day to decisions and consulted with relatives and other health professionals about any significant decisions made in the person's best interest.

When we looked at the medicines consent forms for six people who lacked capacity, we found staff were not acting in accordance with the agencies policies and procedures. This was because some staff were getting people who lacked capacity to sign their consent form and others were leaving it blank. This meant it was not clear how informed consent to support people who lacked capacity with their medicines had been obtained. We followed this up with the manager and the provider who planned to address this with field care supervisors and at the staff meeting the following week. In response to this feedback, the provider also wrote a comprehensive update for the staff newsletter on the Mental Capacity Act and its impact on practice for care staff.

Any changes in people's care or health needs were reported to the agency's office. People's care records and care packages were regularly reviewed and updated as people's needs changed. Staff contacted health care professionals for people when needed, for example, district nurses, occupational therapists or their GP and followed any instructions given. One person said, "I often need to see a specialist. The carer rings around and sorts it all out for me. They are all good and have never been a problem." Community physiotherapists and occupational therapists confirmed agency staff had liaised with them about people's individual needs and followed their advice.

The agency had a comprehensive training programme for all staff. New staff had a four and a half days training which was in accordance with the national Skills for Care common induction standards. Then they worked with a more experienced member of staff to gain further practical experience and their competency was assessed before they worked with people unsupervised. There was a training room at the agency office where staff were taught how to use the equipment they encountered most often in the community such as hoists, electric beds and other moving and handling equipment such as slide sheets. A training matrix showed the agency did a wide range of training which included medicines management, infection control, safeguarding and health and safety.

Staff confirmed they received regular training and were regularly reminded about what update training was due, which they were booked to attend. Staff were also supported and encouraged to undertaken a qualification in care and specific training to meet the needs of individuals they cared for. A registered nurse based in the office trained staff to meet any individual health needs, for example tube feeding or specific pressure area care. The provider had a training development manager to oversee all staff training. They spoke with us about the comprehensive training materials available to staff. They also told us about further planned improvements to undertake mental health training. In response to our feedback, they planned to amend the consent form for medicines for people that lacked capacity to make the requirements clearer for staff.

Field care supervisors carried our regular supervision of care staff through "spot checks" on care staff working in practice approximately every three months. This involved visiting the person's home, seeking feedback from the person and relatives, observing staff carrying out care, and

Good

Is the service effective?

reviewing their record keeping. Staff received praise for good practice and any issues identified had actions agreed to address. Staff confirmed they received regular supervision which they found helpful and supportive. This showed the agency were committed to making improvements, as needed. Staff also received an annual appraisal with a field care supervisor or the manager during which their ongoing professional development needs were discussed.

Each person's nutritional assessment included details about any risks of malnutrition, dehydration or other medical conditions which meant they needed meals/drinks at regular intervals. Care plans included details about people's food preferences and what food they liked to eat. Staff were aware of the need to ensure people had enough to eat and drinks and left drinks and snacks within reach of the person. They were also aware of people's specific requirements. For example, for one person who lacked capacity, staff were aware not to ask the person if they would like breakfast but to present it to them, as they always ate it if it was offered in this way. Where staff supported people with eating and drinking, daily records showed staff included detailed information about this. This meant care staff could identify if anyone wasn't eating or drinking enough and the records prompted them to encourage people and to seek further support if there were concerns. One relative reported some concerns that some staff gave their relatives snacks that were inappropriate for them, which they were dealing with through the manager.

Good

Is the service caring?

Our findings

Most people were happy with the care provided by staff who visited them. One person said, “The ones that come are great and “I am happy with everyone. I have no complaints whatsoever.” Other comments included, “The carers are brilliant” and “I would give the carers 10 out of 10, they are first class”. Another said, “ Most of them are very friendly and chat, but there are some who just get on with the job and go away.”

Many of the people we spoke with had been with the agency for a long time. People who had regular care staff particularly appreciated that continuity because staff knew about their needs and how they liked things done. They said regular care workers discussed general matters of interests with them, and some had formed close friendships and built a good rapport with staff.

People said staff used their preferred name and treated them with dignity and respect. They said staff acted in a professional manner, and were kind and caring towards them. People reported staff supported them with their personal hygiene in a sensitive and dignified manner. For example, one relative said, “She has a full body wash, and help with pads and dressing which they do all in one room. They ensure privacy and cover her with towels. They are really pleasant with her.” Another person said, “The carers are there when I wash or shower. They sit with me as I am unsteady on my feet.”

Care records included good information about people’s family members, any religious preferences, and information about whether they needed glasses to read, had a hearing aid or any other specific communication needs. For example, for one person who was hard of hearing, their care plan instructed staff that the person refused to wear their hearing aids. It suggested staff stand close or sit next to the person so they could gain eye contact in order to communicate more clearly with them.

When we visited the office, we listened to office staff responding to calls from people. We found they were polite, helpful and professional, they took time to give explanations and reassurance to people who contacted them.

Requires Improvement

Is the service responsive?

Our findings

Most people knew how to complain and raise concerns. The office number was clearly displayed on the front of each person's care records so they could contact them. The agency had a statement of purpose and client guide which also provided details of the complaints procedures. This included contact details of other agencies to approach if a person wasn't satisfied with how their complaint was being dealt with.

We looked at complaints received over the past couple of months and saw each was investigated using a structured format with detailed findings recorded. Each complaint was logged, and a report produced which outlined details of the investigation undertaken and the findings. This identified the cause of the complaint, and any action taken to reduce the risk of recurrence as well as lessons learned.

One person said, "I did have a problem with one carer a few months ago and they don't send her to me anymore." They said the manager visited them to discuss their concerns. They reported they were satisfied with how their complaint was dealt with and that the staff member no longer visited them which they were happy about. A relative of another person contacted us directly to say they were very dissatisfied with how the agency had responded to their complaint. They described how they had been passed from one staff member to another and promised return phone calls and e mail information which they never received. As this complaint was complex, we asked the provider to take responsibility for making sure this was dealt with appropriately. We have received confirmation from the provider that they have arranged for a senior person in the company to contact this relative.

The most common complaints people spoke about was late visits, the number of different care staff visiting in any one week, inaccurate rotas and messages not being passed on by office staff and them not getting back to people. This was reflected in the complaints we looked at, and although most people were satisfied with how their complaint was dealt with, some remained dissatisfied as these issues kept recurring.

People confirmed they were consulted and involved in the assessment of their care, and in developing their care plans, and in their regular reviews. They confirmed their care records were up to date and accurately reflected their care needs. Any new information, such as changes regarding medication, were reported to the office who arranged for prescription sheets to be updated. One person said, "(name of field care supervisor) seems to be here every fortnight to discuss my needs".

Staff who visited people were well aware of their daily needs. One staff member told us they reported that one person's health had deteriorated and they needed more than 30 minutes to complete their care. In response, the agency reassessed the person and arranged for them to have a 45 minute visit. Another care worker said they requested a care package be increased, in February, but that it hadn't increased yet. The agency also arranged to review anyone being discharged from hospital to check whether their care needs had changed in order to ensure they received the appropriate support.

Care records were personalised in that they included good details about people's preferences and how they liked things done. They included details of what people could do for themselves and which aspects of care they needed help with. Many people's care plans included details of adjustments made in people's homes to enable them to move independently such as location of grab rails, use of raised toilet seats, wheelchairs and walking frames. Daily entries were made about all care provided and about people's physical and psychological well being.

However, people's care records did not include about the person's life history such as what work they had done or any information about their hobbies and interests. When we asked staff about this, they said they could usually tell this from what they saw in people's home such as by looking at pictures, and books in the house and from getting to know the person. We discussed this lack of individual history details with the branch manager, who said they would look at incorporating this into people's individual assessment. This would mean staff would have more background personalised information about the people they cared for.

One person told us how much they appreciated that a care worker had helped them to maintain their hobby of sewing by setting up their sewing machine for them. However, that staff member had recently moved to another position in the agency and they were missing this support. One relative, of a person who lacked capacity, told us they used a communication diary to stay in touch with care staff

Requires Improvement

Is the service responsive?

about the person. This meant they and care workers were able to give feedback or request anything their relative needed. They said this was very helpful, as they were often at work when agency staff visited.

Requires Improvement

Is the service well-led?

Our findings

At the time we visited, there was no registered manager, although the branch manager confirmed they were planning to submit an application to register but hadn't yet got around to doing so.

Most people and staff said the manager was approachable and was very supportive of them. One staff said, "It's very open, I feel well supported here", a sentiment that most, but not all staff agreed with. Another staff said, "Things seem to be running more smoothly now". The manager said they felt well supported by the provider who visited the branch regularly and was available for advice.

Most people, relatives and staff reported some improvements under the leadership of the new manager but said further improvements were needed, particularly in communication between care and office staff and in office systems. Some people and staff said the office phones were not always answered in a timely way. They commented that if the phone wasn't answered it rang out, which meant they had to keep trying as there was no facility to leave a message.

People said frequently they weren't aware if the time of their visit changed or if a different care worker was visiting from the one on their rota. They also reported messages they left were sometimes not passed on. One service user said, "It's the office that causes me the most issues, I just wish they would ring me when they change the times like from six to eight pm last week. Overall I would say they are not the worst organisation, nor the best I've been with but am not too dissatisfied."

During the inspection, a further organisational change was underway which a relative and a member of staff contacted us directly about because they were so concerned. This related to the provider writing to self-funded people to advise them they had set up a sister agency and that Newcare was transferring all of its self-funded clients to this agency from 29 March 2015. We were sent a copy of the letter which was dated 18 March 2015, which meant people were only given 11 days' notice. They were concerned about the short notice, the lack of choice and the impact those changes might have on the continuity of care staff. The relative who contacted us was also concerned because the person lacked capacity, and they were not informed as the letter was sent directly to their relative's home and they only found out about the changes by accident. We asked the provider to contact this relative to discuss and address their questions and concerns, which they did.

We found care workers and office based staff were also poorly briefed about these changes and observed staff were struggling to deal with people's questions about these changes when we visited the office. The letter stated that where possible, the agency would try and ensure continuity of care workers. However, there was confusion about which staff would be working for the new agency. A care worker said they had not been approached to work for the new agency so didn't know what was going to happen to their clients. We did not think this change was well organised or communicated and it caused unnecessary distress and confusion for people, relatives and staff. We followed this up with the manager and the provider and asked them to contact one relative in particular to reassure them. We also sought further assurances from them that they were confident they had the systems in place to ensure a smooth transition to these new arrangements, which they said they had.

Since we last visited, the agency had developed weekly rotas which were sent to people outlining the times of their visits and the name of the care worker who would visit them. Whilst these were well received, lots of people reported difficulties with the timeliness of the rotas and gaps and inaccuracies with these rotas. One person said, "Times are a real problem. They should be here about 9.30am – 10am but sometimes not until 2pm. The last few months it does seem a little better. I do get the odd phone call to say they are late or I have to ring up. The office staff do try to be helpful". Another person said, "I am not completely happy with the rota, especially for this week. I have no-one for tonight or Friday morning". One person said, "Management is hopeless. They have now given me a rota but it has three blank spaces. The carer down for Sunday won't be here as she is on maternity leave". Another said, "It's not the carers fault but I am getting different times every morning and I have not had a rota for two weeks now. My regular carer is off sick but I need to know times as I need to go out".

Another person said, "I usually have someone here at 7.20pm and do allow for other users and traffic, but last

Requires Improvement

Is the service well-led?

Friday it was 9.30pm and I was getting rather worked up. Nobody told me." Staff also commented on the difficulties in rota planning, one staff member said, "They do seem to get into a pickle in the office working out the rotas".

When we visited six people on Monday 16 March, only one person had received their rota for that week. This was because an office staff member who did most of the weekly rota had been on leave, and other staff had not managed to complete the rota well in their absence. Staff said they aimed to get the rota out by Wednesday each week for the following week. Office staff said high sickness levels meant they spent a lot of time re- arranging staff cover for visits, which resulted in delays in getting rotas sent out. Gaps in the rotas meant staff at the office were still trying to fill visits for that week, which meant further delays in starting the rota for the following week.

The branch manager confirmed staff were allocated travelling time between visits where any distance was involved. We looked at a selection of staff and people's rotas and found that travelling time was inconsistently applied. For example, the same run of visits had travelling time calculated on some days but not others. This inconsistency meant staff were more likely to arrive late where no travelling time had been allocated.

The agency used a monitoring system to ensure people received their visits and that staff stayed for the required length of time. Care staff had to dial into the system to confirm when they arrived at a person's house when they arrived and again when they left, with the person's permission. This was monitored by office staff throughout the day and helped identify any delays or problems and highlighted any potential missed visits so these could be followed up. Late visits were monitored and reported on. Late e visits were counted as any that occurred 30 minutes or more after the planned time. The most recent data available showed 463 of 9043 visits, which meant about five per cent of visits a month were late. The most common reasons reported included the previous person needing additional care, staff sickness and traffic congestion.

We concluded the registered person's systems and processes were not fully effective in organising care visits in an efficient and timely way and that communication with people, relatives and staff needed to be improved. This was in breach of regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010, which corresponds to regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We followed up with the manager what actions were being taken to improve office based systems. The manager told us about plans to improve communication within the office such as to introduce have face to face handover meetings. This included providing further training to staff on rota planning so they were less reliant on one person and plans to introduce a 'template rota'. They said this would improve continuity of care and reduce the amount of time spent planning rotas. This issue had also been discussed last time we visited. The manager explained recent organisational changes made by the provider had reduced their workload in other areas. This meant they planned to concentrate more on this area to embed these changes. Also, they said too many staff were taking their remaining leave during March, which had made staffing more difficult. They outlined improved arrangements for arranging bookings for the following year's leave to prevent this problem happening again. Other improvements introduced were a shift system which meant so the office was open for longer periods each day and at weekends to improve staff and customer support.

Regular audits of care plans, daily records and records of medicines management were undertaken by field care supervisors and the branch manager. One person said , "I think every three months they look at the forms. Someone came about three weeks ago and checked them all." Where any problems were identified these were dealt with through supervision with individual staff and any persistent problems reported to the manager to deal with. For example, all medication charts were audited on their return to the office, and any problems were followed up and investigated and improvement actions identified. Where individual staff were not making the required improvements, staff were sent letters of concern which advised them further action would be taken using the agency's disciplinary procedures. This showed the agency were continually trying to improve standards through monitoring.

The agency had robust training, supervision and appraisal systems that were monitored and reported on regularly to the provider. Further improvements in these systems were being developed with the introduction of electronic

Is the service well-led?

reporting which would identify individual staff compliance with required training. This will identify dates staff were due for update training so they could be booked in advance. The agency were also introducing a new system whereby staff could view their own training record and book training updates online.

Staff meetings were held on a regular basis with several meetings held so that staff had an opportunity to attend. Minutes were circulated to all staff. Minutes we looked at showed important information was communicated, staff were able to raise any concerns and there practice issues were discussed. Office based staff also met regularly and had systems in place to communicate important information to one another between shifts. For example, a written handover sheet and a whiteboard which included information about which staff were off sick and any person who was currently in hospital and didn't need a visit.

We looked at the systems for auditing and reporting any accidents, incidents, complaints and safeguarding concerns and found that where any issues were detected, any necessary action was taken, and recorded, to reduce risks of recurrence. The branch manager reported weekly to the provider on a range of issues as part of the quality monitoring system. For example, recruitment, staff sickness, any late or missed visits, staff training and appraisals. Records of senior manager meetings showed regular monitoring of performance at the Exeter branch and confirmed the provider was aware of any problems highlighted.

The agency did an annual feedback questionnaire to see people and relatives feedback on the service provided. The most recent survey, completed in 2014 showed most people and relatives were happy with the service provided by the branch. More up to date ongoing feedback was obtained from people and relatives by Field Care Supervisors when they visited people to undertake reviews of care plans and to carry out staff 'spot checks'. This was recorded and we saw examples of how this was used to address any day to day problems identified. For example, one person wanted an earlier visit in the morning as they had only agreed to a later one temporarily, which the manager was made aware of and was trying to address.

The agency produced a staff newsletter bimonthly. The February/March addition included an update on the changes in The Care Act due to start in April 2015. The agency had a 'carer of the month' scheme to recognise and thank staff for their hard work and a caring attitude.

The agency also had a staff centre (intranet) where staff could review the agency's policies and procedures although many staff we spoke with were not very aware of this. The manager said more staff awareness raising of this was needed, and we saw this had been included in the monthly newsletter.

The agency used a range of methods to keep up to date with changes in practice and in adult social care. The manager was aware of recently introduced regulatory changes as they had attended a training event. The staff trainer had recently attended Skills for Care event and were aware of national plans for the introduction of The Care Certificate to confirm new staff had undertaken the appropriate induction training and had the required competencies to work in care.

They also told us about how they kept up to date with developments through the Social Care Institute for Excellence, the Alzheimer's society and other national organisations.

The provider had just employed a clinical services compliance manager who started work during the inspection. This was a group wide role which included responsibility for clinical leadership and supporting compliance with CQC standards and regulations at various agencies within the providers group. We contacted this staff member with some issues people and staff identified to us about other services run by the provider and they agreed to follow up and address these.

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 How the regulation was not being met: People were not fully protected by having sufficient numbers of suitable staff at all times to meet people's health and welfare needs. This is a breach of regulation 18 (1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance How the regulation was not being met: The agency's systems and processes were not fully effective in organising care visits in an efficient and timely way and communication with people, relatives and staff needed to be improved. This was a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.