Agincare UK Limited

Agincare UK Andover

Inspection report

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Ratings

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

Overall summary

This inspection was announced and took place on the 20, 22 and 28 October 2015.

Agincare UK Andover is an domiciliary care agency which provides personal care and support to people who live in their own homes in Andover and the immediate surrounding areas. People who receive this service include those living with dementia, people with medical conditions including diabetes and those suffering physical impairments due to their medical conditions. At the time of the inspection they were providing personal care to 73 people.

Agincare UK Andover has a registered manager in place. 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 a 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 they had not always felt safe. The provider had not ensured that people were safe because they had not always provided care and support in accordance with people's individual care plans. People who required two care staff to support them with their personal care needs

Summary of findings

had on occasion's just one member of care staff to support them, resulting in staff requesting assistance from the person's relative. This placed people at risk of physical harm.

People's safety was not always promoted as although risks that may cause them harm in their home had been identified they had not always been managed. There were not always personalised risk assessments in people's care plans detailing actions that needed to be taken to ensure a person's safety when their care was being delivered.

There were insufficient staffing levels to ensure people's needs were being met safely. The provider did not have a system in place to ensure the continuous assessment of staffing levels to ensure they continued to meet people's needs. People had raised concerns with the agency due to repeated missed and late calls. When additional care staff were required the provider did not always seek assistance to ensure there were always sufficient care staff to meet people's needs safely.

People were not always protected from the employment of unsuitable care staff. Recruitment procedures were not always fully completed. The provider had not ensured that a full employment history had been obtained from care staff before they started working for the agency. This is required to make sure that care staff can explain any gaps in their employment to ensure their suitability to work with people.

People were at risk of receiving medicines in a way they were not prescribed. People's medication administration records (MAR) and cream application charts were not always completed correctly so it could not be established whether people had received the medicines required to maintain their health.

People were supported by care staff to make their own decisions. Care staff were knowledgeable about the requirements of the Mental Capacity Act (MCA 2005). The service worked with people and relatives when required to assess people's capacity to make specific decisions for themselves. Care staff sought people's consent before delivering care and support.

People's health needs were met as care staff and the office staff promptly engaged with other healthcare agencies and professionals to ensure people's identified health care needs were met and to maintain people's safety and welfare.

People were not supported to have their assessed needs met by staff with the necessary skills and knowledge. People were sometimes mobilised without the equipment being used in the correct way.

Care staff demonstrated they knew and understood the needs of the people they were supporting. All the people we spoke with said they felt they had a positive relationship with their regular member of care staff. Care staff were able to identify and discuss the importance of maintaining people's respect and privacy at all times.

People had care plans which had not always been personalised to their needs and wishes. People told us that they did not feel that they were involved in the planning of their care. Where people's care plans had been completed fully they contained detailed information to assist care staff to provide care in a manner that respected each person's individual requirements.

People did not always feel their complaints had been acknowledged. The provider had not always ensured that processes were in place to ensure people's complaints were acknowledged investigated, responded to and lessons learnt to avoid a repeat incident. People repeatedly had missed or late calls even after raising concerns with the previous management at the agency.

The provider's vision and values for the service were not known or understood by the care staff and therefore could not be delivered to people using the services.

Quality assurance processes were in place however had not always been used regularly or effectively to gather, capture and then respond to issues identified. People told us they were not able to ensure their concerns were addressed when liaising with management.

We found there to be a number of breaches 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?

Inadequate

The service was not safe

The provider did not ensure that people were supported by adequate numbers of skilled and competent care staff to meet people's needs.

Recruitment procedures were not always fully completed to ensure care staff were suitable to deliver people's care.

Individualised risk assessments and risk management plans were not always in place to ensure people were protected from the risk of harm.

Medicines were not always documented correctly by trained care staff whose competency had been assessed. Documentation was not always completed effectively therefore it could not always be established if people had been receiving their medicines as prescribed.

People were safeguarded from the risk of abuse. Care staff were trained to protect people from abuse and knew how to report any concerns.

Contingency plans were in place to cover unforeseen events such as fire or power loss at the office where personal information was stored. Generalised risk assessments were in place to cover environmental hazards which could cause people harm in their homes to ensure they remained safe.

Is the service effective?

Requires improvement

The service was not always effective.

People were not always supported by care staff who had the necessary skills, knowledge and confidence to meet their assessed needs.

People were supported by care workers who demonstrated they understood the principles of the Mental Capacity Act 2005 (MCA 2005). People were supported to make their own decisions and where they lacked capacity to do so care staff ensured the legal requirements of the MCA 2005 were met.

People were supported to eat and drink enough to maintain their nutritional and hydration needs. Records documented people's preferences regarding food and drink, care staff knew people's likes and dislikes.

People were supported by care staff who sought healthcare advice and support for them whenever required.

Is the service caring?

Requires improvement

The service was not always caring.

Care staff were motivated to develop positive relationships with people. However, they were not always given sufficient time by the provider in order to do so.

Summary of findings

People did not feel that they were always involved with the provider in planning and documenting their care to reflect their needs and preferences.

Care was given in a way that was respectful of people and their right to privacy whilst maintaining their confidentiality.

Is the service responsive?

Requires improvement

The service was not always responsive.

People did not always feel that their needs had been appropriately assessed. Care staff did not review or update care plans on a regular basis. People were not encouraged to make choices about their care and activities.

People had not always felt that their complaints had been effectively addressed however this had improved. People knew how to complain and were happy to do so. Action was taken as a result of complaints raised to ensure there were no recurrences of the issues raised.

Is the service well-led?

Requires improvement

The service was not always well led.

People and care staff did not feel that there had always been a positive culture which allowed them to share their views on how to improve service quality.

Care staff were not aware of the requirements of their role but felt supported by the newly appointed registered manager. Care staff told us they were able to raise concerns however did not feel that the previous registered manager had provided good leadership.

The provider did not have effective systems to regularly assess and monitor the quality of the service. There was no system to promptly identify missed calls. Ineffective quality assurance systems meant there was an on-going risk to the health, safety and welfare of people using the agency.

Agincare UK Andover

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 function. The inspection was planned to check whether the provider was 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 the 20, 22 and 28 October and was announced. The registered manager was given 48 hours' notice of the inspection as we needed to be sure that the people and care staff would be available to be spoken with. This inspection was completed as a result of concerns raised with the local council that people had been experiencing late or missed calls and that care staff were not appropriately trained to deliver safe care to people.

This inspection was conducted by two inspectors and an expert by experience who spoke with people using the service and their relatives by telephone. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service; on this occasion they had experience of caring for someone using domiciliary care services.

Before the inspection we looked at the previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We did not request a Provider Information Return (PIR) from this provider prior to the inspection. This is a form which asks the provider to give some key information about the service, what the service does well, and what improvements they plan to make.

During the inspection we spoke with two people, two relatives, one care coordinator, one member of care staff and the registered manager. We looked at seven care plans, daily care notes detailing the care provided to four people and pathway tracked four people. This involved reviewing these people's records and speaking with them and their relatives about the experience of the care provided. We also viewed four care staff recruitment files which included supervision and training records and care staff booking in sheets for six people which showed the times and dates care staff delivered care to people. Other documents involved in managing the service were viewed which included quality assurance audits, service improvement action plans, eight people's medicines administration records (MARS), the provider's policies and procedures, quality control audits and complaints and compliment.

Following the inspection we spoke with a further eight people, two relatives and three care workers.

This was the first inspection of the agency at this location since they registered to deliver care in June 2015.

Inadequate

Is the service safe?

Our findings

Most people told us they were felt safe with the care staff however one person told us that due to a previous incident they had not always felt this way. This person told us that when they began receiving care from the agency they were hoisted from their bed but this had not been completed correctly and they felt unsafe during this process.

People said they would have been confident to speak out about any form or abuse and harm, or associated risk of harm however one person felt that they were unable to do this. They told us that when they had been expecting to receive two care staff to deliver care only one person had arrived. This had occurred on a number of occasions and led to their relative being asked to assist in the delivery of their care. This had left the person at risk of receiving unsafe care. This had also caused emotional distress to both the person and their relative. This person's relative told us, in relation to missed calls, "Yes, quite a few…on the weekends mostly, obviously if they don't turn up I do it". The person receiving the service said, "I just feel that because they know 'oh her family member will do it' they just don't think we'd better let them know why we can't send anybody".

Risks to people's health and wellbeing were not always identified and appropriate guidance provided for staff to mitigate the risk of harm. People's care plans included their assessed areas of risks for example communication, moving and handling and environmental risks. Although, identified risk assessments did not always include information about action to be taken by care staff to minimise the possibility of harm occurring to people. For example, one person had swallowing difficulties which was identified in both their care plan and medicines risk assessment. No guidance was provided to care staff to identify what actions would have to be taken to keep this person safe whilst eating, drinking and taking their medicines. Another person's care plan said they were totally dependent on people (care staff) to meet their bathing and/or showering needs. No guidance had been provided on how to best support this person to allow them to receive safe effective care.

Care plans were in the process of being updated as a result of the agency's recent involvement with the local authority. We viewed a reviewed care plan which provided specific detailed guidance to care staff about how best to support a person who suffered mental health issues which could make them present with behaviours which could challenge staff. Appropriate guidance had been included within the care plan allowing care staff to see what actions needed to be taken to ensure this person's safety.

There were insufficient care staff deployed to keep people safe and to meet their needs. People told us that care staff were often late or missed visits completely.

When asked about the time of their care visits people told us that their preferences had not always been met. One relative told us, "We told them we want an early appointment on particular days because we go out…today it should have been at 08:00 but the care staff arrived at 10:30am but we weren't here". One person told us that they had been receiving their bed time call at 16:30hrs in order to prepare them for bed which they had previously told office staff this was too early.

Another relative told us that their family member had experienced missed calls, "It was mostly weekends when we first started and then sometimes people on a Sunday didn't turn up". A relative told us, "My family member has double handed visits and sometimes they (the agency) call me and I have to be the second carer". Care staff told us that there not enough staff working each shift to meet people's needs. "It's worse at the weekends, actually there isn't a worse time, it's whenever". This member of staff continued, "I've had a couple of missed calls for one of my ladies." Another member of care staff told us, "The recruitment has improved, there is more one to one continuity, no one can dispute that there wasn't (enough care staff) in the beginning…certainly yes, that's improving".

The registered manager said there had been no systems in place to monitor when missed calls had been occurring. An action plan to address this on-going problem had been created in September 2015 by the registered manager. This stated that office staff would be required to monitor the staff electronic booking in system. This was to assist in identifying late care delivery visits and those calls which could potentially be missed as a result and allowing other care staff to assist.

Inadequate

Is the service safe?

The provider did not ensure that there were suitable numbers of care staff to deploy to be able to effectively meet people's needs. This was a breach of Regulation 18(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Safe care staff recruitment procedures were not always followed by the provider to ensure people were supported by care staff with appropriate experience and that they were of suitable character for their role. The provider did not obtain full employment histories from care staff before they began to deliver people's care. The provider could not identify if care workers had a history of working with adults with social care needs and that any gaps in their employment history could be reasonably explained.

The provider did not have an effective recruitment procedure in place to ensure that care staff provided full employment histories before being deployed to deliver care. This was a breach of Regulation 19(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care workers underwent other recruitment checks to assist in determining their suitability to deliver care. Records showed Disclosure and Barring (DBS) checks were carried out before care staff delivered care. The DBS helps employers make safer recruitment decisions and helps prevent the employment of care staff who may be unsuitable to work with people who use care services.

The provider did not have appropriate arrangements for the appropriate recording of safe administration of medicines. Records did not always accurately show whether people had taken their medicines despite care staff receiving medication training and being subject to competency assessments. Three Medication Administration Record (MAR) sheets for one person viewed showed a number of gaps where it could not immediately be identified that this person was receiving their medicines. From the 24 July 2015 until the date of our inspection their MAR sheets showed they had not been assisted to take all of their prescribed medicines on 24 occasions. This included medication to prevent a heart attack or a stroke. Daily care notes for this person were viewed and it was found they had received their medicines on 22 of these occasions but this had not been documented on their MAR chart. On two of these occasions this person's medicines had not been provided due to care staff not being able to find the medicines and a missed call visit. This had been reported to the office and the medicines located and provided by the afternoon care staff.

Another person's MAR sheets were viewed in relation to their cream application which was required daily. In September 2015 the MAR sheet showed that they had not received their prescribed cream on 18 days. This persons daily care notes showed that they had received the cream on 10 of these occasions but for eight days it could not be shown that they had received any of their prescribed cream. Whilst we could not see that this had had a negative impact on this person's health they had not been not receiving their medicines as prescribed and was at risk of harm as a result. One relative told us "Her carer makes sure she takes her medication by watching her" however we could not show that this was always being completed.

The provider had not ensured that accurate, complete and contemporaneous medication administration records were kept in relation to service users. This was a breach of Regulation 17(2)(c) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff were able to demonstrate their awareness of what actions and behaviours would constitute abuse and provided examples of the types of abuse people could experience. Care staff were knowledgeable about their responsibilities when reporting safeguarding concerns. The provider's policy provided guidance for care staff on how, when and where to raise a safeguarding alert. A safeguarding alert is a concern, suspicion or allegation of potential abuse, harm or neglect which is raised by anybody working with people in a social care setting. Care staff received training in safeguarding people in their care and were due to refresh this on an annual basis.

However, one person had been exposed to the risk of harm as a result of actions taken by a member of care staff. A complaint was viewed which identified that one person had reacted negatively to a member of care staff during a care visit. This member of care staff then left the location leaving this person alone whilst another member of care staff was requested. As a result of being left alone for 15 minutes they suffered a fall and an ambulance was called as a precautionary measure where no injuries were

Inadequate

Is the service safe?

identified. The registered manager completed a personal visit and appropriate action had been taken with the member of care staff to ensure that the situation was not repeated.

People were not always provided with safe care and treatment. The provider had not ensured that action was always taken to mitigate the risk of harm to people receiving care. This was a breach of Regulation 12(1)(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There were detailed contingency plans in place in the event of an untoward event such as a power loss in the main office. People's personal records were securely stored, in the office, in people's homes and on a computer system which could be accessed remotely. This meant that in the event of an adverse situation affecting the office, the registered manager and provider were able to access this information remotely. These processes ensured that people's information was readily available if required and care givers always had access to the most current information on how to best support people to stay safe. In the event of severe weather conditions detailed procedures were in place to ensure that people's safety was maintained by providing alternative care arrangements which included seeking support from other agencies. Risks to the critical functions of the operating of the agency which could affect people's care delivery had been identified and plans documented to ensure continuity of care of people when required.

Requires improvement

Is the service effective?

Our findings

People we spoke with had differing views about the abilities of care staff to meet their care needs. Most people said that they felt that the care staff skills had improved recently. One person told us that they felt that the care staff had the right skills and knowledge to support them to feel safe. "She (member of care staff) knows what she is doing". A relative told us, "I don't know how much training they've (care staff) have had but our care staff is very good and seems to sort my family member out even if he's not very good.". This relative continued, "We used to have (two care staff members names mentioned) and they're always very good as well".

Not all people spoken with shared these views. One person had felt that the care staff were not trained in using manual handling equipment effectively. This person's relative told us "The care has improved a bit recently, I was not confident on the new staff before, they did not seem trained on the hoist for my family member". Another relative told us, "They didn't not put his night catheter in properly". They continued, "I am not totally confident on their competence, I usually have to check that they have done everything for the night when they have gone sometimes as sometimes they forget to deal with his catheter or take out his hearing aids". Care staff told us and records showed they had received recent training and had not been able to deliver care without receiving training topics in mandatory areas including Moving and Positioning and Safeguarding of Vulnerable Adults.

The agency had taken over a number of people and their care packages from other care delivery providers when they had agreed with the local authority to become a primary provider. This also included the transfer of care staff through a Transfer of Undertakings Process commonly known as TUPE. This can occur when a new provider takes over care delivery from another contractor (re-tendering). Care staff who had moved to Agincare due to being TUPEd from other care providers and new members of care staff had not always received an effective induction to Agincare. Training and supervision had been supplied by the provider to enable care staff to complete their roles. However work based competency checks had not always been completed where concerns had been raised about the abilities of care staff to provide specific care in areas such as catheter care. This had been raised in the provider's, service improvement action plan in September 2015. This plan stated that all care staff required to provide this specific care would be subject to competency checks during care delivery. Despite this being identified in the service improvement action plan these checks had not been completed to ensure staff were competent to carry out this procedure.

The provider did not have an effective system in place to monitor when care staff were due to receive additional or update training. A computer system was used where information regarding staff's training dates were included, however this had not yet been fully implemented. The registered manager said they had not yet had the opportunity to input care staff training dates into the system which would have immediately identified those who were due to require additional support Training records were not available to show when care staff had completed their training and when they were due to undertake an annual refresher in core areas of training. This meant that people may not have received care from care staff with the appropriate skills and knowledge to meet their needs.

People were assisted by care staff who received support in their role. Care staff we spoke with told us there were no regular processes in place for receiving supervisions on a regular basis. These care staff told us they could seek support from staff in the office if they wished to raise any concerns or seek additional support. Records viewed showed that care staff had received at least one supervision since the agency had begun delivering care. Supervisions and appraisals are processes which offer support, assurance and learning to help care staff develop in their role. They are required to ensure that care staff receive the most relevant and current knowledge and support to enable them to conduct their role effectively.

People were supported to make their own decisions. Care staff were able to identify the principles of the Mental Capacity Act 2005 (MCA 2005) and demonstrated that they had complied with legal requirements. Professional advice was sought were required to ensure appropriate mental capacity assessments were undertaken. This was in line with the MCA 2005 Code of Practice which guides care staff to ensure practice and decisions are made in people's best interests.

People and their relatives told us people's consent was sought before care was delivered. In care plans viewed

Requires improvement

Is the service effective?

some people had a completed and signed consent to care forms. The completed forms were dated, signed and made clear to people that they were able to withdraw their consent to all or part of the care programme at any time. People and relatives confirmed that care staff would always ask permission before providing care. One person told us, "They (care staff) always respect my wishes and choices, another person said, "Yes, they (care staff) always ask".

People we spoke with were able to provide their own meals or used an external food delivery service. Care plans however detailed people's personal food preferences which would enable care staff to prompt people to prepare meals they enjoyed. A relative told us, "My family member has a regular carer and they have a discussion about what food she wants to have and sometimes she will go out of her way and make her something different like a cheese toastie which my family member loves". None of the care files viewed showed that people were required to be weighed regularly. If noted that people's weight had declined this would be addressed by regular weight monitoring and the implementation of food and fluid intake charts to ensure the person was eating and drinking sufficient to maintain a healthy weight.

Care staff were able to identify and assist in arranging access to healthcare appointments for people when required. A member of care staff had identified a concern about one person's equipment relating to their incontinence care. The daily care notes for this person showed that the member of care staff called the appropriate healthcare professionals and this person was visited by a district nurse. Guidance was provided in people's care plans to assist care staff in identifying when seeking additional healthcare support was required. A care plan for a person with diabetes was viewed, within which was specific advice regarding eating, drinking and a contingency plan should this person refuse their medication. This also included information about when to seek additional guidance from the person's community psychiatric nurse and support worker, contact details of whom were provided. Providing this advice and support was essential in allowing care staff to assist the person to maintain their health and wellbeing.

Requires improvement

Is the service caring?

Our findings

All the people we spoke with said they felt that the care staff were caring in their approach. One relative said, "My family member used to be a healthcare professional and she often says that she wishes she had more people like (care staff member), she often says she wishes she had more people like her because she's a positive person". One person said that in relation to their regular care staff, "She's lovely, I told her she's mine". A customer survey completed in July 2015 was viewed and the following comments noted, 'Carer's attending are brilliant, especially (two care staff names noted).' A relative said, 'The service we received from (member of care staff) was of the highest quality. She is a delightful young woman who always brought life and warmth into my home; it would be hard to find a better carer'.

People were provided with care staff to support them in line with their personal preferences which included male or female care givers where requested. People attempted to build positive relationships with members of care staff but felt that this was not always easy. This was due to not having regular members of care staff providing their care and the feeling that care staff were not happy in their role. One person told us that one member of care staff had said to them, "They (member of care staff) will come in and they'll admit to you, 'I'm not doing the job because I like it, I need the money' and you think, couldn't you do it somewhere else". Only five people told us they had regular care staff and although they knew most of the carers they did not always know who would be coming.

At the time of the inspection people had not been receiving their support from the staff member they were expecting according to the schedule they had been given. One relative had requested and had been receiving a rota however it often was found to be incorrect, they told us "I download it (rota) off of the computer for the week but 99% of the times between ours and the care staff are wrong. Our rota will say that care staff will be here at 8am but it will say 9am on theirs, also if they put a staff name on there 99% of the time you're not going to get that person." The person receiving the person care told us, "I get very frustrated…I suffer with depression anyway and they can't see that if I'm expecting one member of care staff and I get another…I think why do I have you".

The registered manager had recognised the need for people to receive continuity of care and was in the process of implementing care rotas in order to provide all people and staff with accurate and timely rotas. This had only been in place a couple of weeks before the inspection. The agency had suffered with the loss of a number of office staff including care coordinators and previous managers before the inspection. This had placed additional pressure on other members of office staff to prepare the rotas which had often led to them being incorrect.

People's care plans were in the process of being updated and reviewed to ensure they contained all the relevant information required to allow care staff to provide safe and effective care. Reviewed care plans were written in a person centred way. Person centred is a way of ensuring that care is focused on the needs and wishes of the individual. People's care plans included information about what was important to them such as their previous occupations, hobbies and interests, family details and where they had lived previously. Care plans viewed included advice to care staff to obtain information about the person to enable care staff to provide caring and supportive care. The advice stated, 'When providing support we like to put the person at the heart of the service so it helps if we get to know a bit about them as a person rather than just their care and support needs…..some people will be happy to tell you things about themselves, others may value their privacy and not want to divulge too much". The care plans included this personal information about people which care staff were used to demonstrate their awareness of knowing about the person they were supporting.

People told us that they did not feel that they had always been supported to express their views about their care. However this had improved as a result of recent work undertaken by the registered manager to speak to people on a regular basis to ask if people were happy with the care they required. People said they were asked about what they wanted their care to include, one relative told us, "Yes, we were". People told us they felt respected and listened to, one person said "Yes…she (member of care staff) does". A relative told us, "Oh yes she (member of care staff) does". The agency had been working with the local authority to ensure that all people's care plans were updated appropriately. Care staff told us how they involved people in the care they received. One member of care staff told us, "I've been trained in reablement so I can identify if my

Requires improvement

Is the service caring?

clients can do something for themselves…with domiciliary care we're there to promote people's independence and support them as much as possible to (perform person care tasks) without being patronising."

Most people we spoke with told us they were treated with dignity and respect. One person said that when they were not feeling positive care staff responded to them in a caring way, "Yes they (care staff) they do, a couple of times I've said just go away…but they'll say we'll try and come back". This person's relative said, "The other day you didn't want to get up and they talked you up". This positive view was not consistent however; two relatives we spoke with told us that there had been occasions where people's dignity had not always been respected. One relative told us that they had been asked to support their father on what should have been a double up visit. Only one person was available and they were asked to assist. This relative told us, "I have young children and I don't think it's good for them to see their family member half naked". Another relative told us, "Most of them (care staff) respect dad's privacy and dignity but I have in the past had to ask a member of care staff to leave the room whilst my family member was on the bed pan". Care staff were able to evidence how they would ensure that people had their needs met whilst maintaining people's privacy and dignity. This included not leaving people exposed whilst assisting them with their bathroom routine and asking people if they wanted their curtains closed during personal care delivery.

Requires improvement

Is the service responsive?

Our findings

People had not always felt supported to be involved in making decisions about their care and support to ensure it was personalised to their needs. Nine of the people we spoke with said they did not feel that they were involved in the planning of their care. One person told us, "When Agincare took over (care delivery from another provider) I emailed them my care plan but I've not had a review since the new manager took over". Another relative told us, " Two or three months ago our carer went through our care plan and she took it to the office to get it typed but I haven't seen it since, I think there might be a paper one but I'm not sure". Another relative told us, "We do have a care plan now, only recently".

Other people said they had been asked about what they wanted their personalised care to include, one relative told us, "Yes, we were". People told us they felt respected and listened to, one person said "Yes…she (member of care staff) does". A relative told us, "Oh yes she (member of care staff) does". The agency had been working with the local authority to ensure that all people's care plans were written in a personalised way and that people were asked for their opinions regarding the care they received.

Records showed that people's care needs had been assessed and documented before they started receiving care. These assessments were undertaken in people's homes to identify their support needs and care plans developed outlining how their needs were to be met. At the time of the inspection not all people's individual needs and care plans had been reviewed regularly however this was planned to be completed at least every six months. More regular reviews to ensure care plans remained current had been identified as required by the registered manager. Records showed this was in the process of being completed.

The provider had not ensured that effective systems were in place to monitor the incidents of missed or late calls people experienced. Thirty seven complaints had been raised directly with the agency since June 2015. Twenty three of these complaints had related to care staff being late with their care visit or not arriving to complete personal care.

The provider had not ensured that appropriate systems were in place to identify risks to people's health, safety and welfare due to missed care visits. Appropriate measures had not been taken to reduce or remove the risk of missed calls being repeated. This was a breach of Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that complaints were now being effectively dealt with where this had not always been the case. People told us that when they complained previously prior to the registered manager being position they had not always felt they had been listened to. The provider's complaints and compliments management policy stated that it was the organisations policy to welcome both complaints and concerns and to look upon them as an opportunity to learn, adapt, improve and provide better services. It documented the ways people could complain and the timescale for which an appropriate response and resolution should be provided to people.

A relative said, "I didn't think they (the agency) were very well organised to start with I must admit; now we don't have a problem with it." Another relative told us, It has improved and I do feel more confident now". One person told us that when they had complained that action had been taken as a direct result. They raised a complaint with the agency about two members of care staff they did not feel were able to best meet their needs. As a result of this complaint the person had not had care delivered by these two particular members of care staff again.

Requires improvement

Is the service well-led?

Our findings

The registered manager sought to achieve an inclusive and culture where care staff provided excellent care, however this had not always been evidenced in care delivery. People knew who the registered manager was and told us that previous issues regarding care delivery had improved in the weeks prior to the inspection. Care staff had not always felt supported by the previous registered manager but had confidence in the current registered manager, the operations director and the new manager who had recently joined the agency. The new manager was in the process of completing their induction process with a view to taking over the registered manager's position at the agency.

The provider did not have robust quality assurance processes in place to identify issues and correctly address them to drive improvements in the service, for example in relation to monitoring and acting on missed and late calls.

The provider used an electronic call monitoring system to record care staff attendance at people's homes however from the information generated it was unclear whether care had actually been delivered at the right time, by the right number of care staff and for the appropriate length of time. The call monitoring system care staff used to record when they had logged in and log out of an address required a telephone line. Where people did not have or did not wish to allow staff to use their phone line there was no effective process to remotely monitor if care staff were arriving and staying for that persons' required time at the location. The registered manager told us that office staff would have to assume that care staff had been at the location for the relevant amount of time. One person's booking in sheet showed that office staff had documented that care staff had completed a morning visit between 07:00 – 07:30 however this person's daily care notes stated that care staff had not arrived until 09:15 and had only been at the location for 15 minutes.

The provider did not ensure that there were effective systems in place to monitor the quality of the service being provided to people. There were ineffective systems in place to monitor when additional care staff were required in order to provide safe care to people. This was a breach of Regulation 17(2)(a) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Accident and incident forms had not been completed for people when they had suffered an injury in their homes. Accident and incident forms are a way of reviewing actual and potential harm people have experienced in order to reduce the risk of repetition. This would have assisted the registered manager in identifying if there were any specific trends or themes associated with incidents which would allow them to take steps to address the identified issues. The registered manager told us she could not find any of these accident or incident forms but care staff would call in and tell the office staff if there had been an incident. The registered manager had recently implemented telephone quality assurance calls to people where she said she would expect people would tell her if they had suffered a fall or similar accident in their home address or whilst receiving care. This was raised during the inspection and the registered manager said they would be reiterating the use and importance of completing incident and accident forms with care staff.

The provider did not ensure that there were processes in place to appropriately monitor, document and assess the potential risks to people's safety during the delivery of care. This was a breach of Regulation 17(2)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager was keen to promote an open culture within the agency where care staff took responsibility for their actions and provided person centred care. The provider had a written set of values for the service which were to underpin all aspects of care delivery placing importance on valuing people receiving the service as well as fellow employees. These included the provider's aims including, valuing people using the service and fellow colleagues, learning and encouraging a culture of knowledge, expertise and accountability to underpin the service and care delivery and to excel in everything the care staff did. People had not always been receiving care from staff who delivered to these care standards. However people said they had experienced a noticeable improvement in the way the agency was being led which had reflected on the care they were receiving. Compliments received by the agency were viewed and a selection noted, an email read 'His family report that the change in him just a few days is 'amazing'. He looks clean and is loving the attention from the carers'. A written compliment was received which stated, 'Dear Sir, the standard of care I

Requires improvement

Is the service well-led?

receive cannot improve it is and always has been excellent, the people that visit me are always caring, kind, helpful and polite, I would not change any of them, I am grateful to each and every one of them.'

Care staff had not always felt supported by previous office staff and previous managers but told us that this had improved with the arrival of the registered manager. Care staff told us they had also received support from the operations director and the new manager who had started working within the agency. One member of care staff told us, "Both of them, the registered manager and the operations director are people who do it (working within care) for the caring". Another member of care staff told us, "The new manager is absolutely amazing, fantastic, I feel like I've worked with her for years, she gets passionate about things which aren't right. I feel fully supported."

Whilst there had been instability for staff due to previous office staff and managerial moves care staff were now feeling supported by management and felt the agency was becoming well led. One member of care staff said, "The operations director has been absolutely brilliant with us, he's had no problem coming in sitting and chatting with us…he's been a really big support which is a great thing for high up management to be equal to us." The registered manager acknowledged that it had been difficult for people at the start of the agency's delivery of care but said that she and the office staff were always available to be spoken to by care staff, people and relatives. This was agreed with by people we spoke with.

The registered manager wanted to promote a service which focused on people's experiences and sought information on how they could improve the service people received. Feedback was sought from people during regular quality assurance telephone calls and a service user's survey. This survey was to be completed annually but owing to the new establishment of the agency only one had been completed in July 2015. This survey had free text responses to enable people to share their experiences. People were also able to raise their concerns anonymously to minimise the people's fears about provided an honest and complete response. This last survey had been reviewed by the registered and actions identified to address each issue raised. People raised concerns about not receiving rotas and did not know who would be coming and when. During this inspection we could see that action had been taken to address this. The loss of a care coordinator in the office had delayed this process being implemented fully but a full two week rota was available for people on the last day of the inspection, recruitment was on-going for a new care coordinator. Office based staff were also due to receive training on the use of the computer care management system to enable them to become involved in this planning process and assist with rota preparation.

Other people had raised concerns that they did not always receive regular care staff which made people feel uncertain. Action had been taken to address by placing care staff on regular care delivery rounds to ensure consistency for people.

Telephone survey results were viewed for both the 24 September and 5 – 11 October 2015. These showed that people were asked questions including; asking whether or not people were happy with the current service they were receiving and if people had concerns about the service if they knew who to talk to. The results had shown an improvement in people's confidence in the quality of the service provides. In September 89% of people surveyed had been happy with the care delivery service they were receiving which increased to 95% of people asked the same question in October. Overall from July to September 95% of people were happy with the care staff who supported them.

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 19 HSCA (RA) Regulations 2014 Fit and proper persons employed The provider did not have an effective recruitment procedure in place to ensure that care staff provided full employment histories before being deployed to deliver care.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment People were not always provided with safe care and treatment. The provider had not ensured that action was always taken to mitigate the risk of harm to people receiving care.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider had not ensured that appropriate systems were in place to identify risks to people's health, safety and welfare due to missed care visits. Appropriate measures had not been taken to reduce or remove the risk of missed calls being repeated. The provider did not ensure that there were processes in place to appropriately monitor, document and assess the potential risks to people's safety during the delivery of care. The provider had not ensured that accurate, complete and contemporaneous medication administration records were kept in relation to service users.

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing The provider did not ensure that there were suitable numbers of care staff to deploy to be able to effectively meet people's needs.

The enforcement action we took:
We have served a warning notice to the provider telling them they must make improvements. We will follow up this warning notice in the future to check they had made the requirement improvements.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider did not ensure that there were effective systems in place to monitor the quality of the service being provided to people. There were ineffective systems in place to monitor when additional care staff were required in order to provide safe care to people.

The enforcement action we took:
We have served a warning notice to the provider telling them they must make improvements. We will follow up this warning notice in the future to check they had made the requirement improvements.