Care Quality Commission

Sanctuary Home Care Limited

Sanctuary Home Care Limited (Devon Branch)

Inspection report

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Ratings

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

Overall summary

Sanctuary Home Care Limited (Devon Branch) provides personal care and support to people living in their own homes in Plymouth, North and West Devon. At the time of our inspection, 132 people were receiving care in North and West Devon and 124 people were receiving care in Plymouth and surrounding towns.

The service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are responsible for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

At the time of our last inspections in December 2013 the provider had two registered offices, one in Plymouth and one in Barnstaple. The Barnstaple office service coordinated care for people living in North and West

Summary of findings

Devon. It was previously inspected on 5 December 2013 and we did not identify any concerns with the care provided. We also inspected the service coordinated by the Plymouth office which provided care to people in the Plymouth area on 10 December 2013 and found the service was meeting all the essential standards we assessed.

On 12 September 2014, the provider deregistered the Plymouth office. Since that date, the provider has coordinated care in the Barnstaple office for people living in the Plymouth area as well as those in North and West Devon.

We found there were not always enough staff to ensure people received their care at the time they expected. On a few occasions, staff did not turn up and therefore people were unable to receive the support they needed and there was increased risk to their wellbeing. For some of these people, this had meant they had not received their care at the time they should have. The provider was taking action to address these concerns by recruiting additional workers including staff who would be able to provide care quickly if a member of staff was absent without notice.

People said that they had complained about staff not always turning up and new staff, who they had never met, providing care. They commented that despite making a complaint the problems had not been resolved to their satisfaction and on occasions the same problems reoccurred.

Staff were not receiving supervision and appraisals as frequently as the provider's policy identified they should. This meant that they were not being supported well to ensure that they delivered high quality care. The provider said that they had recruited supervisory staff which meant that they were expecting to address this. The provider had some quality assurance systems in place including monthly audits, although we found that these had not always been completed in the last twelve months.

The quality assurance systems assessed the services provided in North and West Devon, but not in the Plymouth area.

People's needs were assessed and there were care plans to address these needs, however care plans were not always reviewed in line with the expected review date. People said they had been involved in the development of their care plans. They also said the staff were very caring and always treated them with kindness, compassion and respect.

The provider had systems to ensure that before staff started providing care to people, appropriate employment checks were undertaken and staff received training to support them in their role. However we found one staff file that didn't have appropriate references. Staff were aware of their responsibility to protect people from harm or abuse. They knew what action they should take if they identified concerns about the safety or welfare of a person. They said they would be confident reporting any concerns they had to the registered manager. Records showed the provider had taken appropriate action when there had been a concern.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010. 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?

Some aspects of the service were not safe as there were not always enough staff to provide the support people needed. There were times when staff did not turn up or turned up late to support a person.

Staff were recruited safely and received initial training to meet the needs of people they supported. There were systems to ensure that medicines were managed safely. Staff knew how to recognise and report abuse.

Requires Improvement

Is the service effective?

The service was not always effective as people sometimes received their care later that they needed.

Staff were not receiving regular supervision and appraisals.

People were cared for by staff who had been appropriately trained. The provider had supported staff to undertake nationally recognised qualifications and had also ensured staff had access to specialist training to meet individual needs including diabetes care and end of life training.

Requires Improvement

Is the service caring?

The service was not always caring as some care was provided by staff who had never met the person, which some people were not happy with.

Care workers were kind and compassionate and treated people with dignity and respect. Staff ensured a person did not receive visits from care workers that the person did not want. People were involved in making decisions about their care and the support they received and they were able to specify when care workers came to deliver care.

Requires Improvement

Is the service responsive?

The service was not always responsive.

People said the quality of service had deteriorated and their concerns about this were not addressed. Complaints had not always been resolved.

People were assessed when they first starting using the service and care plans were developed to support their needs. Care plans had not always been updated in line with planned reviews dates.

Requires Improvement

Is the service well-led?

Some aspects of the service were not well led.

Changes to the administration and management resulted in care not always being delivered at the right time.

Requires Improvement

Summary of findings

The registered manager was supportive and approachable, but was at times too busy to manage effectively. Regional managers and head office staff had not taken sufficient action to support the changes which had taken place.

Some quality assurance processes had not been completed and did not cover all the services provided by Sanctuary Home Care Limited (Devon Branch)

Sanctuary Home Care Limited (Devon Branch)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 28, 30 October 2014 and 5 November 2014 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service across two areas of Devon and we needed to be sure the registered manager would be available.

The inspection team consisted of two inspectors on the first day of inspection and one inspector on the second and third days. As part of the inspection, we visited three people in their own homes and spoke with another three people on the telephone about their experience of the care they received from Sanctuary Home Care Limited (Devon Branch). After the inspection visits an expert by experience spoke with thirteen people on the telephone, asking them about their experience of the care they received. 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 asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed the information in the PIR along with information we held about the home, which included previous reports and incident notifications they had sent us. A notification is information about important events which the service is required to tell us about by law.

During our inspection we visited the provider's Barnstaple office. We spoke with the registered manager, the deputy manager, a team leader, a trainer, three care coordinators, a temporary agency administrator and two care workers. . We also visited the Plymouth locality office where we spoke with the locality manager and the regional coordinator/ team leader. We reviewed the care records of eight people who used the service. We reviewed the records for seven staff and records relating to the management of the service.

We spoke with some people external to the provider organisation. These were a member of a complex care team, a sheltered housing support advisor, a community nurse and a member of a brokerage team, which commissions care from Sanctuary Home Care Limited (Devon Branch) in Plymouth.

Requires Improvement

Is the service safe?

Our findings

There were not always sufficient numbers of staff available to keep people safe. The registered manager said they had had difficulties recruiting staff in some areas where people lived. Eleven of 19 people said staff often turned up late. Four of these people said there had been a few occasions when staff had not turned up at all to provide care to them and they had been left for several hours without the support they needed.

Describing one of these occurrences the person said "Sanctuary care workers that [my relative] needs are not always turning up, sometimes they are late". They also said on one occasion they had to support their relative themselves, which they said had put them at risk as it had involved assisting the person to move. Another of these people commented "One night they left me with nobody to help me to bed….it worried me a lot."

Another person said "The other week I had a terrible day. I waited and waited and nobody came here until 12.00 noon. Nobody rang to tell me what was happening. I had to have breakfast at 12.00 and my lunch gets delivered a little while later." Another person said they were diabetic and that staff did not arrive early enough for them to have breakfast, which meant they felt "shaky and unsafe". Staff said there had been a few occasions when people had not received the care they were expecting. Staff also described how staff supervisions had not taken place because senior staff had had to undertake care because of staffing shortages.

One of the four people, who said staff had not arrived, said they normally had two care workers to support them, but on one occasion only one had turned up and therefore after waiting for a few hours, a relative had had to travel to their home and help the care worker as otherwise it would have been unsafe. The person said that they had complained about this and that the registered manager had visited them to discuss the problems. They added "things have improved and it has not happened since."

Staffing levels were determined by the number of people using the service and their needs. However staff commented that getting enough staff to provide care to all the people was often very challenging. They said, because of these challenges, care workers were not always able to deliver care according to the rotas which people received each week.

This was a breach of Regulation 22 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

The registered manager said they were aware of the concerns, which were largely focussed on the care provided to people living in Plymouth and the surrounding areas rather than in North Devon. The registered manager also said they were spending two to three days each week in the Plymouth locality office to address these concerns.

To support last minute changes to rotas where staff reported in as sick, the registered manager described how two peripatetic care workers had been employed, who could be called on to undertake a shift at short notice. The registered manager added they were planning to expand this peripatetic provision so there would be cover during normal working hours on all days of the week. The provider had an on-call system for people to ring out of their core office hours (9am to 5pm) which team leaders and care coordinators were responsible for managing. This provided people and staff access to support overnight and at weekends where issues arose.

People said they felt safe with the care provided. One person said that their relative "likes to shower by herself so they help her into the bathroom and leave her to do herself, but they stay close by so if she shouted they would be there. They let her help herself but check that she is ok". Another person said they felt "safe and confident" with the staff who provided their care. The provider had systems in place to ensure that children and vulnerable adults were protected from the risks of abuse. A safeguarding adult's policy and a safeguarding children policy were in place, both of which had been reviewed in August 2013. Staff were required to undertake safeguarding training as part of their induction and then refresh training annually. All staff in Barnstaple had received this training, although twenty-five out of fifty-six staff were not up-to-date with the refresher training, according to the timescale decided by the provider. Forty-seven out of fifty staff working in Plymouth had completed safeguarding adults training, of which three staff were not up-to-date with their refresher training.

Staff were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. During the past year, the provider had notified the local authority safeguarding team of ten safeguarding concerns. Three of the concerns reported were concerned with alleged abuse by people other than agency staff. A review of these reports showed staff had acted appropriately. The provider had

Is the service safe?

taken appropriate action, which had included contacting the police and notifying the Care Quality Commission where there was a concern which had potentially involved their staff.

People were protected from abuse. Staff said where they had a concern about a person they would raise the issue with staff in the office who would then follow the relevant procedures. One member of staff based in the office said they reported any safeguarding concerns that were raised by care workers to the Devon Safeguarding team and would then investigate if advised to do so. Records showed the actions which had been undertaken to address safeguarding concerns which included reporting them to the police.

When a person was first referred to Sanctuary Home Care Limited (Devon Branch), an assessment of their needs, as well as an assessment of any risks to the person using the service and to staff, was undertaken by the registered manager or a deputy. The assessment included the need for manual handling, the use of specialist equipment such as hoists required, their physical and mental health and their mental capacity. Risk assessments included information about action to be taken to minimise the chance of harm occurring, including the need for staff to work in pairs to support the person with their care. There was evidence in care records that the needs of the person were translated into detailed instructions for care staff to follow when delivering the care. The records contained daily notes made by care staff showing that they had undertaken the care that had been recorded in the care plan.

The provider had systems to identify the risks to people of not receiving care in the event of an emergency such as staff being unable to get to them because of snow. People were prioritised into one of three levels based upon criteria, which included whether they lived alone or had family or friends close by, whether they were able to mobilise without support. However, a review of the priorities list showed it had not been recently updated as it did not contain all the people receiving care from the provider. There was also no evidence that the priority status was used in situations where it was known that care workers were going to be late.

The provider had systems to ensure that, when they recruited staff, they undertook checks on a candidate's suitability. These included satisfactory references and an up to date Disclosure Barring Service (DBS) check for the person prior to them starting work in a caring capacity. Staff completed an induction programme which included role specific training and were subject to a probationary period lasting a minimum of six months which was signed off by the registered manager if they were satisfied with the care worker's performance. All the staff records we looked at provided details about the person's recruitment, their references and a DBS check, their training, qualifications and details of supervisions and appraisals. We did raise a concern about one member of staff's references, which had not included references from the person's previous employer. Both referees were from friends of the staff member. The registered manager said that she would investigate this further.

The provider had a medicines management policy and procedure, which included audit processes.

Staff were expected to undertake medicines training when they first started working for the provider and were then expected to refresh training annually. The training plan identified 49 out of 56 staff in Barnstaple (88%) had undertaken medicines administration training, but only 6 staff (11%) had refreshed their training in the last twelve months. 48 out of 50 staff in Plymouth (96%) were up to date with their medication training.

The policy stated that people should be supported to self-administer medications to maximise their independence and retain control of their lifestyle. When asked, two people said they administered their own medicines. We saw evidence in care records that people had been risk assessed in relation to administering their own medication and had signed a declaration which stated that they were doing so.

The registered manager said that they did not support any people to take controlled drugs. She said that where staff administered medicines to people, medicine administration records were completed. These records were audited when care plans were reviewed. The audit records showed that checks on medications had been carried out in line with the policy.

There were eighteen people assisted with medication. We reviewed one person's care record where the person was supported with their medication. The care record had a discrepancy between the medications recorded on a

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medications summary sheet and the medications which had been hand-written on another page in the care record. The registered manager said that they would ensure that this was corrected.

The provider information return (PIR) stated that three medication errors had taken place in the last twelve months. There were records of these errors which showed appropriate action had taken place, including checking with the GP where a medication had been wrongly administered. One of the errors reported were caused by staff from another care provider, rather than Sanctuary Home Care staff. Where the error had involved the provider's staff, there were actions to support those staff with additional training and supervision.

Requires Improvement

Is the service effective?

Our findings

Although people said the individual care they received was effective, eleven people commented that the care was not always provided at the times they were expecting which sometimes meant that the care did not meet their needs. People said staff were knowledgeable and had the skills required to meet their needs. One person described the care workers as "excellent at their job" and another person said they responded to their individual needs. A relative said that the team that visited her mother were "wonderful". One person said "They treat me with care and respect. They cater for my individual needs." However one person said "Carer turned up at eleven instead of ten at the weekend which is too late for me to have breakfast." Whilst another person said "The lack of local knowledge of distances between clients causes carers to arrive late. If somebody is late, the office don't have the decency to phone and tell you."

People said the office did not always ensure that they received care at the time they were expecting and the management systems did not work effectively. For example people said "They are too far away in Barnstaple. They don't know the area, they don't realise how long it takes to travel around down here…they don't understand us" and another person commented "The office are the problem. For example on last week's rota there was no name on Saturday – phoned [the office] but they never respond."

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. Care records showed that people had had their mental capacity assessed. Care workers said that they were aware of the MCA and if they had a concern about a person's capacity in a particular area, such as managing money, they would report this to the office so that an assessment could be undertaken. However although 89% of staff in North Devon had undergone MCA training, in the Plymouth area, only 10% staff had completed this training according to the training records. This meant that staff might not recognise that some lacked capacity in some aspect of their life and might not take appropriate action to ensure that this was assessed.

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. A senior member of staff said that where there was a concern about a person's capacity to make a specific decision, they would work with the person, their GP and family to arrange a mental capacity assessment to ensure their legal rights were protected.

People said that staff were knowledgeable about their role. One person commented "The carers are very experienced, they know their job." Staff received training to support them in their role. The provider had a training plan which showed what training staff needed to undertake and how frequently the training had to be refreshed. Staff were expected to complete training in fire safety, first aid awareness, child protection, food safety, health and safety, infection control/hand hygiene, manual handling, safeguarding adults and medication training annually. In addition staff had to complete training in data protection, dementia awareness, needs of the service users, person centred care and the MCA.

Training was delivered to groups of staff and on a one-to-one basis by an in-house trainer in both Barnstaple and Plymouth. There were training records for individual staff members maintained by the trainer. The training records included both the date the course was undertaken and the expiry date where training had to be refreshed. Training records showed that there had been 43 training sessions run during September 2014. We spoke to one member of staff who was on a training course during our visit. They said that the training they had received had been very thorough. One member of staff said that they had dementia training "which had helped them deliver care more effectively." The registered manager said that a new trainer had been appointed to support training in Plymouth and that this post would address the deficits in training in that area.

However one member of office staff said they had "been thrown in at the deep end" although they had received support from other members of the team and another member of office staff said that they had not had a proper induction into their new role but learned as they went along. This meant that staff might not be effective during the initial period of taking on a new role.

Staff were encouraged to complete nationally recognised qualifications, such as the Qualification and Credit Framework (QCF) and National Vocational Qualification (NVQ) in Health and Social Care at levels two and three. One member of staff said they had been able to complete

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Is the service effective?

their NVQ Level 2 and were planning to start their NVQ Level 3 shortly. Another member of staff said they had been supported to complete their NVQ level 3 qualification. Training records showed that over 40% of staff had completed or were in the process of completing an NVQ. This supported staff to further increase their skills and knowledge in order to be better able to support people with their care needs. This showed the provider encouraged staff to undertake qualifications which would support them in their role. For example, one staff member said they had completed a course on end of life care. They said there were a number of staff who had also done end of life training so that the provider was now able to offer a service to people who were near the end of their life.

External training providers were used to deliver some specialist training, including diabetes care and end of life care. Staff said this had helped them provide more effective care to people with those specific needs.

The provider's supervision policy and procedure identified that staff should meet with their line manager at least six times each year. Five of these meetings should be to discuss their work with at least one involving a practical supervised practice session. In addition, staff should expect to have an annual performance appraisal. The registered manager said that, because of staff shortages at management level, it had not been possible for all staff to have had as many supervisions as identified in the policy during the last year. One member of staff who supervised care workers confirmed they had not been able to undertake supervisions or appraisals with staff as frequently as they were expected. They said this was because they had often had to deliver care to people due to staffing shortfalls. The registered manager said that a number of new appointments to team leader posts had been made and they expected to be able to address the lack of supervisions and appraisals once all the appointments were in post. This meant that staff were not always routinely supported to ensure they delivered high quality care. However, staff said they felt well supported by the manager and the supervisory team and were able to ask for advice when needed. One member of staff said they had received two practical assessments by a team leader in the last year and these had helped them to reflect on and improve the way they worked.

People using the service said they or their relatives coordinated most of their health care appointments and health care needs. However, care records showed that staff liaised with other health and social care providers if they felt there was a problem. For example there was evidence where one person's needs had become greater and staff had worked with the local authority to increase the care they received to address these needs.

People's care records included the contact details of their next of kin, their GP and other community staff that provided care to them, so staff could contact them if they had concerns about a person's health. We saw evidence that staff had contacted a relative when they had had a concern. A sheltered housing staff member said the care workers informed them of any concerns about the people using the service so that any issues would be followed up promptly.

Requires Improvement

Is the service caring?

Our findings

Eight people using the service said there were occasions when someone they had never met, would turn up to deliver their care. Five of these people said they were not very happy allowing staff they had never met into their home, particularly when it involved personal care such as helping them to wash. One person said "Care workers who have previously not visited and therefore are unknown to [my relative]". Another person said "They sent a new girl who had to read the care plan before she could undertake any care. Nice girl and did the job but I was not very happy that I get people I don't know and haven't even met before". Two people said that they had complained about having care workers they did not know and that it no longer happened.

People said they were thought staff were caring and kind. One person said the care workers were "kind, considerate, respectful and treat me nicely" whilst another person commented "I only have to ask them and if they can do it, they will. I'm very happy with all the [staff] that come here".

A relative of a person who used the service said "[Care workers], you couldn't wish for nicer, excellent at their job. They are friendly and ever so kind. They treat us with dignity and respect…I can't speak too highly about them, they are just like friends. The carers come here for my husband but they help me as well in lots of ways. Before they leave they ask me if I need anything more and often they just sit and talk a while".

Staff respected people's dignity and privacy. For example we saw evidence that one person was assisted to get into the shower, but that staff would then withdraw whilst the person had the shower as they preferred to do this on their own.

A member of staff talked about the end of life care they had provided to some people, supporting their preference to die in their own home. Staff said that whilst they did not normally provide care on a 24 hour basis, on these occasions they would do so if needed to ensure the person and their family were fully supported.

One member of staff said that they "loved the job as it makes a difference to people". They described how they enjoyed helping people to be as independent as possible.

The care plans contained evidence that people had been involved in the development of the care plans and that their preferences were taken into account when delivering the care they received. People said their care plans were reviewed with them regularly and they were consulted about changes that were made. We observed staff changing visit times to suit a person's requirements on a specific day. One person said they would phone and talk to the office if they needed an earlier visit because of an appointment and that this was accommodated.

Staff said that they had an understanding of the importance of treating people with dignity and respect. Training records showed that staff had received a training course in dignity and respect and also courses in person centred care (levels 1 and 2). Most staff in both offices had received dignity and respect training. 93% of staff in Barnstaple had received training in Person Centred Care Level One and 21% had received training in person centred care Level 2. 56% of staff in Plymouth had received both person centred care Level 1 and Level 2. This showed the provider supported staff to understand the importance of providing person centred care delivered to ensure the person's dignity and respect.

Some people commented that if they did not want a particular care worker or preferred a care worker of a particular gender, the office staff would make a note of this and ensure that the person's wishes were taken into account when rotas were organised. Staff showed us the computer system used for rota administration and how they could update people's preferences for times of visits and other preferences such as which care workers they did not want. However, although people said they thought the care workers who supported them responded to their needs, eleven people who lived in the Plymouth area said they had problems now that their care was organised by the Barnstaple office. The problems included staff not arriving on time, rotas which were sent to people having no names attached to specific visits on the following week and different staff turning up than those expected. One person said "The [care workers] are very nice but I get too many faces in here, Often they are late because the office don't give them time to travel from place to place. They have been late but they always turn up".

Requires Improvement

Is the service responsive?

Our findings

The provider had systems in place to record written complaints. People said they knew how to make a complaint. All written complaints were recorded and investigated in a timely fashion, but some people said their complaints had not been resolved. Eight people commented they did not have confidence that a complaint would be dealt with to their satisfaction. All of these people were based in the Plymouth area and most commented that the situation had been made much worse since the changes to the administration had taken place. They said that although they had complained, there had still been occasions when no-one had turned up to provide care, despite calling the office. For example one person said "[You] don't know where you are with the office. [I've] complained to Head Office but they don't pay any attention." Whilst another person commented they had complained to the office staff in Plymouth and Barnstaple but did not feel that anyone listened.

This was a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Three people, who said they had complained after they had missed visits, said the issues had been resolved to their satisfaction after the registered manager had visited. People in North Devon all said they found the management and office staff responsive. One person in North Devon said they "had numbers to call in Barnstaple and I'm confident that I could contact the office if I needed".

People said the care workers were helpful and would respond to their individual needs. One person said the care workers discussed his needs with him and were flexible with how they helped him. A relative said "They let her help herself but check that she is O.K. They support my Mum but they keep her independent. They go the extra mile to make sure that the care they give her suits her needs."

Care records showed people had been initially assessed and detailed plans had been developed based upon these assessments. Staff were knowledgeable about the care they provided to people and were able to describe people's wants and needs. People said they had been involved in the development of their care plan. One relative described how they and their Mother had been involved in the development of the Care Plan. They said they felt that their wishes were taken into account and they were confident that the person received the care they needed. Staff said care plans were meant to be reviewed every six months, however due to staff shortfalls, some reviews had not been able to be undertaken for all the people within these timescales. Six people were unsure whether their care plan had been reviewed. Eight people said their care plan had been reviewed and discussed with them in the six months, although five people said it had been a year or more since the last review. However, people said that staff were responsive to their needs and would always do what they asked. One person described how they felt their individual wishes were taken into account and any changes they wanted were listened to. They also said their relative had been fully involved in any changes to the care provision.

Requires Improvement

Is the service well-led?

Our findings

The service was not well-led in all aspects. Some people said that they found the management of the service had deteriorated since changes to the administrative offices had occurred. For example one person in the Plymouth area commented "When the management went it started to go wrong. They are too far away in Barnstaple." Another person said "[You] don't know where you are with the office. I complained but they don't pay any attention. Lots of staff leaving and constantly get new people, who are not introduced." Another person said they had written to complain to the head office, but that "it seemed pointless" as part of the complaint had been about the registered manager and it was the registered manager who had responded.

The registered manager had been in post in the Barnstaple office since 2013. They had taken over responsibility for the Plymouth area in 2014 and spent part of the time in the locality office near Plymouth.

The registered manager described how the service had undergone a number of challenges over the last year due to the changes in Plymouth which had also affected staff in Barnstaple. They said that they and staff in the provider's head office recognised that they still had a number of challenges but that they were working with staff to overcome these. The registered manager said that they felt supported by head office staff and also by other service managers in the southwest who they met at monthly manager's meetings.

The provider had communicated with staff about the changes to the office arrangements. Regional managers had visited and discussed the plans with the registered manager and with staff in both areas. The registered manager said that there were still staffing problems in the Plymouth area with low morale and high levels of sickness. The weekend prior to the inspection visit, the registered manager said six staff had not turned up for work as they had reported in as sick. This meant rotas had had to be changed at short notice.

Whilst there was evidence that the provider had planned the changes to the service, there was a lack of evidence that the impacts on staffing and provision of care had been fully considered. This had resulted in a number of problems including changes to care which people were unhappy with. The provider had not been able to address all the concerns which meant that people were still dissatisfied. There had also been an impact on staff which meant that staff had not been adequately supported and trained. Some staff said they felt the regional and head office managers did not understand the problems that the changes had caused. One member of staff commented they didn't see senior managers from the provider's head office very often and they didn't have confidence in them.

Staff said they found the registered manager was supportive and was very approachable. However, they said that because of the changes, the registered manager's workload had increased so that there were times when it was difficult for her to do everything that was needed in a timely way. They added the previous year had been very challenging due to the changes that had taken place, which had resulted in a number of staff being demoralised and unhappy with the new arrangements. For example, staff had not received the amount of supervision and support for their role as they would normally expect at the agency. Staff said they thought "things were improving" and that "we have turned a corner", but they also recognised that there were some challenges that lay ahead. The registered manager said there had been staff shortages but a recruitment drive meant they had filled a number of vacancies, including some supervisory roles. .

Staff said they thought the additional supervisory roles would enable staff to feel better supported. Staff said they believed the new appointments to team leader and deputy manager posts would help ease the pressures. An example of an area where there had been problems was the on-call rota, which care coordinators, team leaders and in-house trainers were expected to participate in. The on-call rota operated from 5pm through to 9am each night during weekdays and from 5pm on a Friday through to 9am on a Monday at weekends. Staff who did these rotas said in recent months they had to deal with a large number of calls, which were mainly from the Plymouth area caused by staffing issues. These staff expressed concern about the volume of calls due to the lack of care staff in Plymouth and the impact this had had on other staff and themselves. Staff said the number of rotas they had to cover each month should be reduced, now that more team leaders had been appointed.

Supervisory staff said that because of the shortage of care workers, they had had to undertake some care work to

Requires Improvement

Is the service well-led?

ensure that people received care. This meant that they had not been able to ensure staff received supervisions as frequently as the provider's policy stated. They also said that some people's care plan had not been reviewed every six months. They said that with the new team leaders and deputy manager in post, they now expected to be able to address the backlog.

The registered manager said there was a temporary member of staff who had been recruited to introduce new filing systems for both staff records and care records. The staff member had completed the system for all Barnstaple files and was in the process of working on the Plymouth files to ensure that they were complete, accurate and in a logical order.

The health and social care professionals we spoke with said that they found the staff very helpful and friendly. They said "care staff have been quick to report problems back to the office who then contacted them for support and advice." They gave an example of a person who needed additional equipment which had been identified by Sanctuary Home Care staff. They said that they had liaised with the complex care team and the occupational therapist who had then been able to provide the equipment.

The provider did not have a quality monitoring system in place which covered all the areas they provided services to. The most recent manager's self-assessment quality audit of the service for the North Devon area had been completed in October 2014. However the audit which was supposed to be carried out monthly had not been done for several months prior to October. There was no quality audit undertaken for the Plymouth area. The audit of the service in North Devon included information about new service users, service user reviews completed, new staff, training activity, staff performance monitoring, complaints, safeguarding and CQC notifications. However it was not clear how improvements were going to be made or when they would be done by.

Sanctuary Home Care had surveyed people's opinion about the service in North Devon during 2014. 68 people (44%) had responded to the survey. Although there had been a slight downward trend compared with the survey undertaken in 2013, the provider had received positive feedback on care and support, privacy and dignity, communication/information, safety and security with an overall positive rating of over 90% satisfaction with all the criteria. However the provider had not undertaken a similar survey of people living in the Plymouth area.

A quality audit for the North Devon area had also been completed, which included interviews with service users and staff by a senior manager from the providers head office in June 2014. This had identified issues where the location was not in line with the provider's policy including evidence for the need for a training plan for staff. There were no recent quality assurance audits for the Plymouth area.

This was a breach of Regulation 10 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations 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 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing The registered person did not have suitable systems in place to ensure there were sufficient numbers of suitably qualified, skilled and experiences persons employed.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA 2008 (Regulated Activities) Regulations 2010 Complaints The registered person did not have suitable systems in place to ensure that any complaint made is fully investigated and, so far as reasonably practicable, resolved to the satisfaction of the service user, or the person acting on the service user's behalf. **Regulation 19(2)(c)**

Regulated activity	Regulation
Personal care	Regulation 10 HSCA 2008 (Regulated Activities) Regulations 2010 Assessing and monitoring the quality of service providers The registered person did not have systems to regularly assess and monitor the quality of all the services provided in the carrying on of the regulated activity against the requirements set out in this part of these Regulations. **Regulation 10 (1)(a)(b), (2)(b)(i)(iii),(c),(e)**