Shores Homecare Limited

Shores Homecare Limited

Inspection report

29-31 Seaside Road
Withernsea
HU19 2DL
Tel: 01964 615190
Website: www.example.com

Date of inspection visit: 26 & 30 November 2015
Date of publication: 29/01/2016

Ratings

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

Overall summary

This inspection took place on 26 and 30 November 2015 and was announced. The domiciliary care agency was last inspected on 14 November 2013 and the regulations in force at the time were being complied with.

Shores Homecare is registered to provide personal care for people in their own homes. The agency also provides other support such as administering medicines, meal preparation and social support. On the day of the inspection 47 people were receiving a service from the agency. The main agency office is located in the seaside town of Withernsea in the East Riding of Yorkshire. Staff provide a service to people that live in Withernsea and other surrounding areas of Hornsea and Aldbrough, also in the East Riding of Yorkshire.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post. A registered manager is a person who has registered with the CQC to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Summary of findings

People told us they felt safe whilst receiving a service from Shores Homecare. People were protected from the risks of harm or abuse because the agency had systems in place to manage any safeguarding concerns. We saw that staff required an update to their training in safeguarding adults. We have made a recommendation about this.

Systems were in place for the management and administration of medicines. However, the agency was unable to identify if mistakes occurred. This meant errors were not recognised or acted upon.

The training records evidenced that some staff had completed induction training and training on the topics considered to be essential by the agency. Some staff had achieved a National Vocational Qualification (NVQ). However, we saw gaps in both the training and induction that staff had received.

We saw from training records that staff had received no formal training in the principles of the Mental Capacity Act 2005 (MCA) with the exception of the registered manager. We have made a recommendation about this.

There were systems in place to seek feedback from people who received a service from the agency. However, we saw the feedback had been analysed but was not used to identify any improvements that needed to be made nor was any response shared with the people providing the feedback. The systems in place to monitor and improve the quality of the agency provided were not effective. There was no evidence of audits to drive continual improvement and to learn from any incidents that occurred at the agency. We have made a recommendation about this.

Staff had been employed following the agency recruitment and selection procedure which ensured that only people considered suitable to work with vulnerable people had been employed.

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

People expressed their satisfaction at the support they received with administering of medicines, meal preparation, cleaning and support with shopping.

People told us that they had been included in planning the care provided to them and that they agreed with it. People had an individual plan, detailing the support they needed. People had risk assessments in their care files to help minimise risks.

No complaints had been received by the agency in the last 12 months. People told us they were confident that if they expressed concerns or complaints these would be dealt with appropriately.

The people who used the agency told us that the service was well managed.

You can see the actions we have asked 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?

Requires improvement

The agency was not always safe.

People were protected from the risks of harm or abuse because the registered provider had systems in place to manage any safeguarding concerns. However, we saw staff required an update to their training in safeguarding adults.

Assessments were undertaken of risks to the people who used the agency and the staff team. People who used the agency told us they felt safe.

Staff were recruited using robust policies and procedures. There were sufficient numbers of staff employed to meet people's identified needs.

People told us that they were satisfied with the assistance they received with the administration of medication. Systems were in place for the management and administration of medicines. However, the agency was unable to identify if mistakes occurred. This meant errors were not identified nor acted upon.

Is the service effective?

Requires improvement

The agency was not always effective.

The agency registered manager was able to show they an understanding of the Mental Capacity Act (MCA) (2005). However, we found that no staff had received training in MCA.

Staff had received training in key topics but had not completed refresher training within the required timescales. We saw no evidence of staff receiving a completed induction programme into the agency.

People had their health and social care needs assessed and plans of care were developed. People who used the agency received additional care and treatment from health based professionals in the community where required.

Is the service caring?

Good

The agency was caring.

People and relatives told us that staff were caring.

People's privacy and dignity was respected by the staff and this was confirmed by the people who we spoke with.

People who used the agency told us they felt included in making decisions about their care whenever this was possible.

Is the service responsive?

Good

The agency was responsive.

The people who used the agency were able to make choices and decisions about their lives. This helped them to remain as independent as possible.

Summary of findings

People's needs were assessed and reviewed by the agency. This meant that staff were able to meet peoples individual care and support needs.

The people we spoke with knew how to make a complaint or raise a concern with the agency. They told us they had no concerns but were confident that if they did these would be looked into.

Is the service well-led?

Requires improvement

The agency was not always well led.

People expressed satisfaction with the consistency of the service. There were opportunities for people who used the service and staff to express their views about the service that was provided by the agency. However, there was no evidence that people's feedback was listened to and acted on.

The systems in place to monitor and improve the quality of the agency provided were not effective.

People who used the agency told us they found the manager was approachable and the agency was well led.

Shores Homecare Limited

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 26 November and telephone calls took place to people who used the agency on 30 November 2015. The inspection was announced and carried out by one adult social care inspector and one expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service; the provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office to assist us with the inspection.

Before this inspection we reviewed the information we held about the agency, such as notifications we had received from the registered provider, information we had received from the East Riding of Yorkshire Council (ERYC) Contracts and Monitoring Department and Safeguarding Team.

During the inspection we visited two people (with their permission) in their own homes and one visiting relative. We spoke with 10 people over the telephone, two relatives and one member of staff and received feedback from one community professional. The registered manager and the responsible individual (the person with whom we make contact) were present during the whole site inspection and we will refer to them as the 'agency managers' throughout the report.

We spent time at the agency office looking at records, which included the care records for five people and the medicine records for four people who used the agency. We looked at the recruitment, induction, training and supervision records for three members of staff and records relating to the management of the agency.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe when the agency staff were in their home. Comments included, "They are lovely and I feel safe with them," "Yes, I look forward to them coming" and, "I feel safe at home I am better here than anywhere else; during the day they give me company."

The people who we spoke with who had assistance to take their medicines told us that their medicine was administered on time. They told us, "They do my eye drops and see that I get the right tablets," "Medication is given to me and they make sure that my morning medication is ready for me to take" and, "They give me my medication in a timely manner."

There was a medicine policy and procedure in place at the agency. We checked four peoples completed medicine records in their care plans held at the agency office. We saw areas of concern that included missed signatures, unclear entries in the carer's notes section of the medicine records and no signatures for medicines that had been hand written on the records. Signing and countersigning of handwritten records is considered best practice as the second check helps to reduce the risk of errors occurring. For example, one person's medicine record had a medicine added part way through the month of September 2015. This had been handwritten with only one signature. We discussed this with the agency managers who told us that medicine records were brought into the agency office every month to be looked at and any issues dealt with. We were unable to evidence any formally recorded process for checking medicine records or any learning from events that had occurred. This meant there was no effective medication auditing system in place and errors were not identified nor acted upon. The agency managers agreed to address this. We saw that each person's care plan included a risk assessment for self-administration. This information was reviewed by the agency on a regular basis.

We checked the agency training record and saw that 12 staff had completed medicine training in 2013/2014 and 10 of those staff had attended refresher training in July 2015. However, we saw that one staff member, recently started with the agency, had no recorded medicine training. We saw evidence that the person had completed shadowing with a care co-ordinator and was shown the medicine records and deemed capable by the person assessing. We discussed our concerns with the agency managers who told us the staff member received medicine training during the induction period which was in April 2015 and had completed an NVQ 2 qualification which included medicines. We were unable to verify this in the documents provided at the inspection.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

We looked at the way the agency managed risks. We saw risks associated with the person's care were recorded in people's care records. We checked the care records for five people that used the agency and saw they all contained risk assessments that recorded the safety of the person in their home environment. These included information on medicines, utilities and the physical environment inside and out. We saw an assessment of the support the person required with moving and handling, stairs, personal care, dietary needs and communication. We saw all of the risks had been assessed in January 2015. No-one using the agency received 24 hour care; instead they received set calls at times which had been agreed throughout the day. This meant people were supported to keep themselves safe and well.

We saw the agency had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. The agency managers were able to clearly describe how they would escalate concerns, both internally through their organisation or externally should they identify possible abuse.

We saw the agency training record which showed that 11 staff had completed safeguarding training in 2013 and we saw evidence that one staff member had completed safeguarding principles as part of their NVQ Level 2 qualification in 2013. We saw two staff members had no recorded evidence of safeguarding training. We discussed this with the agency managers who told us both had completed NVQ qualifications which included the principles of safeguarding vulnerable people. However, we were unable to verify this as the agency did not have the records on the day of the inspection. We discussed this with the agency managers who told us they were aware that staff training required updating. They told us recently other issues such as recruiting staff and covering calls to people using the agency had taken priority and previously booked training courses had not gone ahead as planned. We saw evidence of a workshop for safeguarding had not

Requires improvement

Is the service safe?

gone ahead as planned for 20 November 2015. They assured us the whole staff team would be refreshed in safeguarding adults training as soon as possible. One staff member told us, "If I was concerned about any of the people I support I would report immediately to my manager. People who are not provided with enough food, who have bruising or if money is missing can be signs of abuse."

We found the agency had information about safeguarding referrals and investigations that had been completed. We saw evidence of discussions with the local safeguarding authority, supporting evidence and internal investigations that had been completed. We were able to verify these with notifications we had received. This demonstrated to us that the service took incidents seriously and ensured these were fully acted upon to keep people safe.

Through discussions with the agency managers and people who used the agency we found that staff at times handled money for the people whose care they delivered. If staff carried out shopping tasks for anyone that used the agency then the money received from and returned to the person was documented in their care records. This meant that an audit trail was in place to ensure the person was protected from any potential abuse.

We saw that incidents were recorded and kept in the persons care records with details of the nature of the incident. However, information on how the incident was evaluated or recommendations put in place to ensure similar incidents did not occur, was not always available. This meant 'trends' may not have been identified at an early opportunity. We discussed this with the agency managers who agreed they would look at auditing incidents more effectively as part of their quality assurance process.

We saw there was an 'on call' system for outside of normal office hours seven days per week. This included contact names and numbers of the care co-ordinator on duty and which area this applied to. The agency managers told us that a high number of people who used the agency had a Lifeline call system in their homes which allowed them to summon help in an emergency. People we spoke with told us they had never had any problems contacting any of the agency staff.

The registered manager told us the agency were continually recruiting for new staff and the agency rota was completed on a 'four day on four day off' basis which allowed continuity in staff for the person using the agency. They told us the local job centre; local newspaper and the seaside radio station were all used for advertising. We saw an advertisement displayed in the reception area of the centre for recruitment of care staff.

We looked at three staff personnel files. We found the recruitment process included application forms which recorded the person's employment history. There were two references and a completed health questionnaires to show they were fit to carry out the role. Documents were provided to confirm the person's identity and checks were made by the agency with the disclosure and barring service (DBS). The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. These measures ensured that people who used the agency were not exposed to staff that were barred from working with vulnerable adults. Interviews were carried out and staff were provided with job descriptions. This ensured they were aware of what was expected of them.

The agency employed approximately 14 care workers and area co-ordinators. The agency managers told us the agency rota was completed on a four weekly basis to cover all of the areas in which people lived. We looked at the duty rota from 23 November to 20 December 2015. These indicated which staff were on duty and in which area. A colour coded system identified if staff were on holiday, covering another area, were based at the agency office or attending training. During the inspection we asked people who used the agency if they felt there was enough staff to support them. They told us, "Yes, someone has always come to me. I have two regular staff that I have got to know" and, "Yes, I know the same one is coming for four days and then another comes for four days." Another person told us that they sometimes asked for an increase to their allocated hours at short notice and the agency could always accommodate this request. This demonstrated the agency was able to meet people's needs.

We recommend the registered provider sources safeguarding adult's refresher training for all staff from a recognised training provider.

Requires improvement

Is the service effective?

Our findings

We asked people who used the agency if they felt the staff were skilled and experienced to care and support them to have a good quality of life. They told us, "Yes, they are all great," "Yes, a lot of them have worked in care homes and looked after people" and, "I get all the help I need to keep me independent." A relative told us, "The carers are all excellent and have the correct skills for [name] needs".

We looked at induction and training records for three staff to check whether they had undertaken training on topics that would give them the knowledge and skills they needed to care for people who used the agency. The agency managers told us the induction paperwork formed part of the recruitment of all staff employed by the agency. We saw documentation that new staff shadowed more senior staff at the start of their employment. We found that the agency had begun to use the 'Care Certificate' self-assessment tool as part of their induction, which was introduced by Skills for Care in April 2015. Skills for Care are a nationally recognised training resource. 11 staff had completed this. The agency managers told us they had prioritised from this, areas staff had identified as a training refresher need. However, this plan of training had not yet gone ahead. One staff member told us, "I don't remember if I had my induction straight away. I worked alongside another carer for one day and then worked on my own." We were unable to evidence a completed induction programme from any of the records we looked at. The training records indicated nine out of 14 staff had no recorded induction with the agency. We discussed this with the agency managers who showed us a new induction programme they planned to introduce.

We saw that the staff team had accessed training deemed by the agency managers as essential. Evidence on the training record showed that 14 staff had completed essential training such as moving and handling, medicines, fire safety, safeguarding and first aid. However, there were gaps on the training record and we saw only one out of 14 staff had completed training on infection control in 2008 and four staff had no recorded fire safety training. This was fed back to the agency managers who assured us all staff training would be reviewed and updated. The manager and 13 other staff had completed National Vocational Qualifications (now known as QCF Diplomas, qualifications and credit framework) at various levels.

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

Checks of the staff files showed that they received regular supervision from their line manager. Each staff member had a supervision contract in place which stated that formal supervision would take place every six months and additional sessions may be requested. We found supervision records were written in detail and discussed team communication, rotas and any training needs identified. The records we saw indicated that staff had attended a supervision meeting in 2015. The agency managers told us that care co-ordinators and the registered manager used a communication book to record all discussions and issues and that staff were in daily telephone contact with the main agency office. This meant there was evidence to show that each member of staff's progress was monitored by the agency to ensure they were carrying out their role effectively.

The agency managers told us that spot checks were carried out on staff practices in the community, but these were not always documented. They told us that they would make sure these competency checks were recorded and any feedback given to the member of staff would be included in supervisions.

We did not see any evidence of staff appraisals. This was discussed with the agency managers who confirmed the agency were "behind on staff appraisals." One staff member told us, "I am booked in now and again for supervision and staff meetings are held as often as possible but this can be difficult." This meant staff did not get the opportunity to reflect on practice and identify areas for future improvement.

People who used the agency either had full capacity to make their own decisions about their care and well-being or they had a family member acting on their behalf and this was recorded in their care record. We saw in one person care records they had been supported by the agency and other professionals to access advocacy services. An advocate is someone who supports a person so that their views are heard and their rights are upheld.

People we spoke with told us that the staff only carried out personal care when they had asked for consent. Comments included, "Staff always ask if they are doing what I want them to do," "They ask consent before carrying out

Is the service effective?

personal care and other tasks; they have the skills for the tasks they have to do for us" and, "Ask consent before personal tasks are carried out, the carers are nearly always on time and can be a bit rushed if they are late."

Where people had a person acting as their Power of Attorney (POA) this was clearly recorded in their care records. A POA is a court appointed person with the legal right to make decisions regarding health and welfare or finances. If a person is unable to or no longer wishes to make those decisions, a person can be appointed to do that on their behalf in their best interests.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the service was working within the principles of the MCA. We saw from the agency training record that staff had received no formal training in the principles of the Mental Capacity Act 2005 (MCA) with the exception of the registered manager. One staff member we spoke to told us, "Capacity is about if the person can make their own decisions. If I had any concerns around this I would go straight to my manager." People's care records indicated MCA assessments or decisions had been made in the person's best interest. Best interest meetings take place when informed choice cannot be made by the individual, and includes the views of all those involved in the individual's care. This indicated the agency was working with a basic awareness of the principles of the MCA.

People who used the agency told us they were able to discuss their support at any time. One person who used the agency told us, "The manager speaks to me regularly to ask if I am ok, as does [Name], the care co-ordinator." This indicated that there was good communication between the agency and people who used it.

We saw that peoples care records included information on nutritional needs; diet, nutritional screening and any issues from swallowing and loss of weight. One person who used the agency told us, "I have help with my food and drink. I have never had any problems and see the diabetic nurse and dietician when I need to." We saw records of meals provided to people were completed when prepared by care staff. This meant relatives and other care staff were able to check that people were receiving food that met their nutritional needs.

Information in individual care records indicated that people who used the agency received input from other health care professionals such as GP and social workers. People who used the agency told us, "My friend sorts out my GP appointments but if I was that bad I know the staff would do this for me. Shores have told me if I ever have to go to hospital they would sort it out for me," and, "I see the diabetic nurse." Any contact with health care professionals was documented in the person's records. This meant staff were aware of people's health care needs so that they could provide appropriate support.

We asked staff how information was shared with them if a person's needs had changed. One person told us, "I would contact the manager and a review would be organised and the staff team notified. If calls are changed, for example, a person goes into hospital; we will receive a text message letting us know."

We recommend the registered provider ensures all staff are trained in the principles of the Mental Capacity Act 2005 (MCA).

Good

Is the service caring?

Our findings

We did not observe any staff interacting with people using the agency during this inspection. However, people who used the agency said they were happy with the care and support they received from staff. People told us, “Staff are kind,” “Yes, they are caring and [Name and Name] do a lot for me” and, “It’s nice that they are here.”

People who used the service told us they were involved and supported in planning and making decisions about their care and treatment. People said, "Staff always ask me if I can and want to do things for myself first" and “I have control, I haven’t lost my faculties.” This demonstrated that the care delivered was what people wanted.

We found each person had folders containing their personalised care records, medicine administration sheets and daily logs. The care records we looked at included up to date risk assessments for tasks such as medicine giving and falls. The staff completed daily notes to show what care and tasks had been carried out. We saw the care records we looked at were reviewed in 2015. People’s individual care records were held in their accommodation and a copy at the main agency office. This meant they were accessible only to those who needed them.

From discussions with people who used the agency and the records we looked at we saw that people had good relationships with the staff team and the agency managers and were able to discuss any concerns or worries they might have. People who used the service told us, “The carers care about me on social occasions they bring me home to make sure that I am safe, they listen to me and if I have a problem they act upon it for me and they now help me to write,” “The carers are very caring and do what is required and give me a little company it is very lonely here” and, “The carers I have are caring and kind- they listen to me and talk to me, one of my carers has written my Christmas cards, they also check that I am comfortable.”

Everyone who we spoke with told us that staff cared about them. Relatives of people using the agency told us, “The carers are kind and caring and listen to me and act on what I say they make sure that my [Name] is comfortable. They are very good to us and one of the carers is wonderful” and, “The carers chat to [Name] all the time, they know likes and dislikes and are interested in [Name]. They make sure that [Name] is comfortable and encourage independence.”

People we spoke with told us that staff recorded information in their care plan at each visit to ensure that all staff were aware of their current care needs. One person told us, “Yes they check my plan and ask how I am and if I have been ok.” The agency managers told us that daily record sheets were returned to the office periodically by the care co-ordinators. We were able to verify this in the records we saw at the main office. This meant agency staff could check that recording was accurate, appropriate and that any concerns identified were passed to the main agency office staff.

Peoples care records included information for staff regarding the way in which they were to provide care and support to people. They included ‘Good day/bad day’. One person told us “I feel they have got to know me and that’s great.”

We asked people if their privacy and dignity was respected and comments included, “Yes” and, “They treat me with dignity and respect”. One person who used the agency told us, “The staff always ask me first if I want to dry myself or if I want them to do it for me.” We saw 24 people who used the agency had completed a survey about the agency in 2015 with 100% of those confirming they felt respected. We also noted an acknowledgement from a relative in the local newspaper on how the agency had treated their loved one with respect.

We saw people’s wishes regarding end of life care were sought and recorded as part of the care planning process. People were able to make advanced decisions and these were recorded. An advance decision (sometimes known as an advance decision to refuse treatment, an ADRT, or a living will) is a decision a person can make to refuse a specific type of treatment at some time in the future.

Good

Is the service responsive?

Our findings

People told us that they received the care they needed and that the agency staff were responsive to their needs. One person told us, "If my son and daughter in law want to have a day out the staff will re-arrange and come at short notice to help me." A relative told us, "We have cancelled this weekend and they have been fine. They are very accommodating."

We saw that the support needs assessment completed on individuals was based on information gathered from the person themselves and from the support plan provided by the local authority that commissioned the service (when they funded the care package or were involved in the person's care). The assessment included information about communication, dietary needs, environment, next of kin and GP. Discussion with people who used the agency indicated they had an awareness of the contents of their care records. They told us, "The carers read my care plan when they come in, my daughter was involved in the planning of my care and the plan has been reviewed," "I was involved in identifying the care I require" and, "I was involved in my care plan and the help that I require for the service, the carers go through the book and sign after each visit. My son is also involved in my care."

The care records we saw were person centred. One part of the care records we saw was a life story; this described the person, people who were important to them and their previous employment. Other care records were held on nutrition, medication and pain management, capacity and consent, mental health, memory and continence. This meant that staff had information that helped them to get to know the person.

People who we spoke with told us that staff usually arrived on time; some people said that they were always on time within reason and if they were going to be too late the care co-ordinator would ring to let them know. People told us staff always stayed for their allocated time and no-one that we spoke with had experienced a 'missed' call. This meant that people were receiving the level of service that had been agreed with them.

We noted one person's plan of care had been changed to reduce the risk of falls and to support the person to remain independent at home. We saw the agency had worked with other partners to secure sensors to be fitted in the person's home and a Lifeline call system. The agency had tailored the allocated call times so they were earlier in the morning to support the person with getting up and reduce the risk of falling. This meant that the person had been listened to and their individual needs met.

The main agency office was located within The Shores Centre which provided office space for local charities and other community based organisations. A number of social activities and outings were available which people in the community could access if they wanted. This included a luncheon club every month, a social group for older persons every Friday and a Parkinson's support group every Monday; the agency managers told us this group had been set up building on an idea from a physiotherapist. The centre had a cafe on the premises which people could access. The agency managers told us people's friends and relatives encouraged them to join some of the groups that were available. We saw people were in and out of the centre throughout our visit. We noted the centre was fully accessible for people with disabilities and disabled parking spaces were available. One person we spoke with told us they used to go to the café but now chose to spend their time watching sports and quiz programmes and completing jigsaws and crosswords in their home.

People who received a service told us that they knew how to make a complaint and were able to name a person who worked for the agency who they would speak to. One person told us, "I would get straight in touch with [Name]." A relative told us, "If I had any complaints I would go down to the centre." Checks of the complaints/compliments file kept by the agency showed that they had not received any formal complaints in the last 12 months.

Requires improvement

Is the service well-led?

Our findings

As a condition of their registration, the agency is required to have a registered manager in post. There was a registered manager in post at this inspection who was registered with the Care Quality Commission (CQC) in February 2013.

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

The agency managers told us they provided a localised service to Withernsea, Hornsea and Aldbrough. They said customers rang up personally after hearing about the agency via word of mouth and the agency also received referrals directly from the local authority.

This was a small agency and the people who used it and their responses to our questions about the quality of the care they received were positive. People who used the service described it as very good. They told us, "The service is well led" and, "The manager is very good and the service is well led."

Our observation of the agency was that it was well run and that the people who used it were treated with respect and in a professional manner. We asked the agency managers about the values and culture of the service. They told us, "Our main value is to ensure the person always has their calls when they need them. We are working to achieve better integration and flexibility for people in all areas and to value our staff more. Communication is key to what we do". We asked people who used the agency if they felt it was well managed. Comments included, "I know one or two of the senior people who have been to my home and the service seems well-led."

People told us that they were supported by the same group of staff and that this only changed if staff were on leave or sickness absence. One person told us they received support from one care staff four times a day and that this was provided by a group of two care staff who alternated with each other every four days.

The agency encouraged open communication via the use of annual surveys for people who used the agency; we checked the 24 responses in the most recent survey in 2015. One person had commented, "If my carer isn't available how do I find out who is standing in." We saw that the agency had evaluated all of the responses into percentages based on the number of people who had completed the survey. We saw that feedback from people in their surveys was not evaluated. This meant that the surveys were ineffective for the people using the agency, as people were not told what action had been taken as a result of completing them.

We found from observations that the agency focused on giving people good, consistent quality care, but some records and documentation needed further development. The agency managers told us there was on-going daily communication between the community and agency staff on care records, accidents/incidents, complaints, staff training, staff meetings, supervisions and medicine administration forms. However, these were not detailed or fully recorded with action plans to show how issues raised had been managed or learned from. We discussed this with the agency managers who said they were aware of the need to improve the quality assurance process and that this would be done as soon as possible.

We saw all staff had signed a confidentiality agreement upon commencing work with the agency. All care records were stored by the person in their own home and at the agency main office. During our inspection we asked for a variety of records. We found these were well kept, easily accessible and stored securely. We saw that daily logs were intermittently returned to the agency office; the daily logs showed that staff recorded the time they arrived at a person's home and the time they left. These documents were accessible to the staff and were easily located when we asked to see them.

The agency did not have a system in place to manage missed calls. They relied on people contacting the office to report that staff had not arrived as expected, or for staff to contact the agency office when this had come to their attention. The agency managers told us they had an electronic call monitoring system in place in the past but the communication they currently had with staff, families, and care co-ordinators worked more effectively. The agency had an 'on call' rota available seven days per week to support with this.

The agency had good links with other community partners. The agency managers told us staff had been recruited within the community and the agency worked closely with the local leisure centre. The agency managers attended a

Requires improvement

Is the service well-led?

local community crime prevention group with representatives from the Humberside Fire and Rescue Service, the Police and a carer's support network group. One person who used the agency had suffered a burglary in their home. This was discussed at the crime prevention group to look at safety measures to support the person to be safe. The agency staff were made aware to be vigilant when visiting the person's property and safety measures were suggested to the person which included the use of a key safe and to lock their door at all times.

We recommend the registered provider ensures a robust quality assurance process that drives continuous improvement.

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 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Safe care and treatment.** People who use services were not protected from the risks of unsafe treatment because there was no effective system in place to identify medicine inaccuracies. Regulation12 (2) (g).

Regulated activity	Regulation
Personal care	Regulation 18 HSCA (RA) Regulations 2014 Staffing **Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Staffing.** Persons employed by the agency did not receive an appropriate induction programme nor have their training needs reviewed and updated at appropriate intervals. Regulation 18 (2) (a).