Age Concern Manchester

Age Concern Home Care - South Manchester

Inspection report

Age Concern Manchester Crossacres
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Date of inspection visit:
18 February 2016
23 February 2016

Date of publication:
13 June 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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We inspected Age Concern on 16 February, 18 and 23 February 2016. The first day of inspection was unannounced. The service was last inspected in May 2014, when it was found to be compliant in all the areas we looked at.

Age Concern is a domiciliary care agency providing personal care to 112 people in the surrounding areas of Wythenshawe. Care workers support the people using the service with a wide range of personal care needs and domestic duties, including assistance with shopping and making meals.

The service had 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 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People told us that they felt safe when using the service. Staff we spoke with could tell us about safeguarding and said they would report any concerns to their managers. Training records we saw confirmed that staff had undertaken this at induction and on refresher training.

People had an assessment prior to receiving a service and risks were identified before the commencement of care. Managing those identified risks was not always made clear for staff as risk assessments in place were basic and did not contain enough information.

The recording of medicines administration was inconsistent. Incorrect paperwork was used by staff on occasions and a medication error was not fully investigated. Due to the length of time since the last review of care plans, information on these was often wrong or out of date.

Staff told us that they found the training good and told us it prepared them for their caring role. The company employed a member of staff in a training co-ordinator role. They provided training to staff on a one to one basis at times. If an employee was identified as needing or benefitting from additional support then this was made available to build confidence and develop the staff member.

The provider had adopted a traffic light toolkit. This identified when staff required updated training in certain areas, such as administering medication or safeguarding. Additional training and experience was made available to staff that needed it in other company settings, including a day centre and a residential care home. This benefitted staff and gave them confidence in the caring role.

People and their relatives told us that care workers were caring and supported people's privacy and dignity. Care workers we spoke with could give examples of how they promoted people's independence and we saw examples of this during our visits to people's homes.

Care workers could demonstrate that they knew people well as they could describe their likes, dislikes and preferences, although documentation of these in care plans was limited.

People's personal information was stored securely however, information relating to staff was not always appropriately stored.

None of the people or relatives we spoke with had made a formal complaint. Records showed that the service acted upon the written complaints it had received in 2015 in accordance with their complaints policy.

Staff meetings were held and we saw minutes from these meetings. The service held two staff meetings on the same day, discussing the same agenda items. Staff were able to choose the most appropriate session to attend based on their working pattern and home life commitments.

The service had recently introduced spot checks of care staff but there were no completed records at the time of the inspection. Other audits of the service such as medication and care plan reviews were not done or were out of date.

Staff we spoke with felt supported by management and had no problems raising any issues or concerns with senior management.

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 service was not always safe.

People told us that they felt safe when their care staff were visiting. They were complimentary about staff and how they were treated.

Staff were aware of the safeguarding policy and procedure and would raise any concerns with the manager.

Risk assessments did not always give clear and specific guidance as to how staff should manage people's risks.

The administration of medication was not always appropriately recorded. It was not clear what action had been taken following an identified medication error.

Staff practices minimised the spread of cross infections and promoted good infection control.

Is the service effective?

Requires Improvement

The service was not always effective.

People told us they had confidence in care workers' skills and abilities although they considered some to be better than others.

There was a good in-house trainer who delivered induction and refresher training. Other training opportunities were made available to staff.

The service used a toolkit to indicate staff competencies in the role.

There were no capacity assessments on care plans and consent to care was not managed appropriately.

Is the service caring?

Good

The service was caring.

People and their relatives told us care staff were kind and caring.

Staff had built a strong rapport with people using the service but still maintained professional boundaries.

Care staff we spoke with demonstrated their understanding of how to maintain people's dignity and independence.

People were signposted to and used an advocacy service.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was flexible when required and responded to requests from people to alter their care visits.

Reviews of care plans had not happened for some time. Information contained on care plans was out of date or wrong in some instances.

Care plans were basic and lacked detail around people's likes, dislikes and preferences.

The service had an up to date complaints policy and procedure. People told us they knew about this and would use it if they needed to.

Is the service well-led?

Requires Improvement

The service was not always well led.

Staff felt supported by the registered manager and they felt listened to.

Staff meetings were held and were well attended.

The manager felt supported by the wider network of Age UK colleagues.

There were no effective systems of quality checks and audits in place therefore improvements were not identified or implemented.

Age Concern Home Care - South Manchester

Detailed findings

Background to this inspection

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

This inspection took place on 16,18 and 23 February and the first visit was unannounced.

The inspection team consisted of two adult social care inspectors and a bank inspector conducted telephone interviews. Before the inspection we requested 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. The provider returned this prior to the inspection taking place.

Before the inspection took place we gathered and reviewed the information we held about the service, including any statutory notifications submitted by the service and the PIR. We contacted other healthcare professionals involved with the service including the local authority safeguarding team, commissioners of care and a senior social worker. We spoke with a district nurse during one of our home visits and received positive feedback about the service.

We spent the first and final day of inspection at the service's registered address speaking with the registered manager, the training co-ordinator, two care assistants, a senior carer and a member of the office staff. We looked at a variety of records, including five people's care records, six staff recruitment files, staff training and supervision records, policies and procedures and other documents relating to the management of the service.

On the second day of inspection, we visited seven people who used the service in their own homes and

spoke with two relatives. Telephone interviews were conducted with a further three staff and five people who were using the service. In addition to this we observed some staff supporting people during our visits to their homes, for example administering medication and with the provision of meals, and looked at paperwork relating to their care after obtaining the individual's permission.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe when they used the service and they said that they did. One person who used the service told us, "I do feel safe always." A relative told us, "Mum feels very safe with them (the carers)" and a third person told us, "I do feel safe. I don't worry anymore." Other relatives also told us they thought their family members who used the service were safe.

The service outlined in the Provider Information Return how they ensured the safety of individuals using the service. This was by the provision of safeguarding training in accordance with the local authority's policy and a company safeguarding policy that all staff were made aware of at the point of induction.

We asked the care workers we spoke with to describe the forms of abuse people using the service might be vulnerable to and they could. One member of staff we spoke with was fully aware of the different types of abuse and described them to us. They were aware that if any abuse was witnessed or suspected then this needed to be reported to the manager or a senior member of staff; they told us, "I would definitely tell my manager straight away." The same member of staff told us they would have no qualms in whistleblowing and knew about the company's policy. They were confident that if a concern was raised it would be dealt with. "It would be followed through," they told us. We were confident that systems were in place to enable staff to raise concerns and that staff were able to identify, recognise and respond to symptoms of abuse to ensure the safety of people using the service.

We checked the service's recruitment procedures to see if staff employed in the service were suitable to work in the caring profession. We looked at the recruitment records for six care workers. The personnel files we looked at contained appropriate documents in relation to the recruitment process including the original application form, written references, proof of the right to work in the UK and copies of photographic identification. All files we checked had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups.

One personnel file we looked at contained the original DBS certificate. The storage of this document on an employee's personal file marked a breach of confidentiality by the company and was not in line with their own confidentiality policy which stated that disclosure information would never be kept in an applicant's personnel file. The person had been employed with the authorisation of the Chief Executive of the company. We saw an email on file to this effect and reasons for this approach. There had been no formal risk assessment of the candidate undertaken in relation to the job role applied for and the nature of the job. This was pointed out to the registered manager and the area manager and by the end of the inspection a more formal approach was in place in the form of a DBS Risk Assessment process and supporting paperwork.

We saw that environmental risk assessments had been identified and completed for people using the service and were on care plans where applicable. Examples of environmental risk assessments included pets, the neighbourhood, friends and various aspects of the home environment such as the kitchen or the stairway. This meant that the service was aware of environmental risks when providing care to people in

their homes and had assessed and documented them appropriately.
People's risk assessments however, were not always appropriately documented. Care plans we looked at contained information in relation to risks that had been identified for individuals. For example, one care plan noted that the person could not have any meat and all foods must be soft but the risk assessment did not inform care staff how to fully manage the risk and prevent the person from choking.

One care plan identified that an individual wore glasses and it was documented that they had poor eyesight and another person was identified as having poor mobility. Both were considered to be high risk of having falls. Risk assessments were basic and merely indicated the level of risk as being high, medium or low. Not enough information was made available to care staff and the paperwork in place did not fully outline what actions care staff could and should take to reduce the risks posed to individuals.

This constituted a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(b).

Some of the people using the service were supported with their medicines. When we visited people in their own homes we looked at their care plans, after being given permission to do so. We saw that the recording of administered medication was inconsistent as the correct paperwork was not always available. In one file we could not find an entry for the administration of medication after 9 February 2016. The care plan reflected that medication should be administered to the person on a daily basis. We checked the stock of medication and this indicated to us that it had been administered. The person confirmed that they had been given and had taken all medicines.

We found records of administered medications on financial recording sheets or daily progress sheets, not on the company template to record the administration of medicines. This was the case in more than one property. Some care workers were not proactive in supplying new sheets to accurately record the administration of medicines. A record must be kept of all medicines administered to the person the service is caring for using the right paperwork. This information is an audit trail and is vital to other care workers who visit the person as they could administer medication incorrectly causing harm to the person. We made the registered manager aware of the issues with the recording of medicines administration and they assured us that improvements would be made.

A log made on 7 January 2016 indicated that a person's Friday tablet was missing. There was nothing on file to indicate what had been done as a result of the person not being given the medication, nor any log of what action had been taken with the person, other professionals, family and care staff. The lack of medication reviews, lack of updates to care plans in relation to medication support and missing medication could, and on one occasion did, lead to medication not being administered and therefore people were placed at risk.

The issues with medication constituted a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 12(2)(g).

Electronic call monitoring was not being used by the service at the time of our inspection. However the registered manager told us that Age UK planned to introduce the system,' Call Round', during 2016. If the service identified, or were made aware of, any timing issues with any calls undertaken there was a process in place to address this; care workers contacted the on-call facility at the start of each visit. This meant that management were able to monitor when visits took place and were satisfied that people's safety was being maintained. It was expected that when the electronic call monitoring system was introduced the monitoring of call visits would be greatly improved and the co-ordination of visits made easier.

All the people we visited using the service received assistance from care workers with their personal care, for example, with washing and dressing and continence. At the time of our inspection we were told and we saw that staff did not wear uniforms. We asked people if care workers used personal protective equipment, such as gloves and aprons, when assisting with personal care. All of the people we spoke with said that care workers used gloves and aprons.

We saw two members of staff put on clean aprons and a new pair of gloves whilst undertaking their visits and before providing care. One care worker we spoke with told us they had raised concerns with the manager about a dirty cat-litter tray in a person's kitchen which was attracting flies. "It wasn't hygienic," they told us. After notifying the office of their concerns, it was raised with family members and the tray was later cleaned and moved. This showed us that staff were aware of infection control, raised concerns appropriately with management and took measures to prevent cross-infections occurring.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and their relatives told us that the service was in the main effective; they trusted the care staff and told us that they had the right skills and attitude for the caring role. "The service is very good,", "[I'm] getting all I need," and "I have no complaints. Staff are great with me," were some of the comments we received from people using the service.

Some people using the service considered some care staff to be more competent than others. "[They] all do a job but some do it better than others," we were told. Three people we spoke with told us that some visits had previously been haphazard and rushed but that situation had settled down in the last couple of weeks. Staff and managers confirmed this, pointing out that sickness levels over the Christmas period had been high.

A member of staff we spoke with told us about the training on offer. "I have done loads of training." They spoke highly of the training and told us it prepared them for the caring role. Another member of staff agreed and also considered the training to be good. "It equipped me for the job," they told us. This member of staff told us that they had completed NVQ level 3 and had also undertaken training courses in end of life care, dementia care, palliative care, abuse, medication and food hygiene.

We saw a training matrix which outlined training staff had undertaken to date or indicated when refresher training was due. Mandatory courses were on the matrix and some examples of mandatory training included safeguarding adults level 1, medication administration awareness, fire safety, health and safety, moving and handling theory and practical, food hygiene and infection control.

Staff new to care were supported through the Care Certificate. The Care Certificate is a set of standards to be worked towards during the induction training of people new to care. It helps care workers develop the values, behaviours and skills needed to provided high quality and compassionate care.

Additional training was available to staff in the form of distance learning using booklets from a training provider. These could be completed and submitted either manually or on line and included aspects of care around mental health, dementia, end of life and infection control.

Following the induction, staff gained further experience by going out with senior care staff and shadowing other colleagues. It had been identified that one new carer needed more support before providing personal care on a one to one basis. This was provided in the form of shifts at a local care home also owned by the company. The manager explained that the individual was able to gain valuable experience in a care environment whilst under closer supervision and this had led to the staff member gaining confidence in the role. Until they were fully comfortable and confident in the caring role any domiciliary calls undertaken by the individual would just involve cleaning and meal preparation.

A new member of staff we spoke with confirmed they were not yet fully confident in the caring role. They told us that the induction had involved watching DVD's but explained that they were better at hands-on

work rather than watching. The member of staff was positive about the role especially about the experience gained at the company's day centre. When asked if managers were supportive she told us, "Yes definitely. I've never had as much support."

The service had recently implemented the traffic light system, a practical tool that indicated the competencies of staff and graded them accordingly. Staff assessed as "green" on the chart were deemed to be fully competent in the caring role and were able to undertake all duties. Those assessed as amber or red were identified as requiring additional training in some areas, for example with the administration of medication or health and safety and therefore did not undertake certain duties until these training needs were met.

Supervision sessions were in the form of catch-up meetings and staff confirmed that these were happening, although not consistently for all staff. Staff we spoke with found these meetings with the manager useful and they told us they could raise any concerns they had. Any identified training needs were discussed during these meetings and any personal development requests could be raised. Staff told us there had been spot checks carried out recently which they saw as another form of supervision.

The service provided care and support to people who sometimes lacked capacity to make certain decisions for themselves. We looked at what consideration the service gave to the Mental Capacity Act 2005 (MCA) and checked whether the service was working within the principles of MCA.

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.

One of the care plans we looked at contained signatures of family members as well as the signature of the client; however, it was not clear if the person had capacity. In other care plans, members of the family had been involved in making decisions regarding the care for the individual and had signed their consent, but there was no evidence on file to suggest that the people using the service lacked mental capacity. Family members must have 'lasting power of attorney' for health and welfare decisions before they can consent for the person. When this is in place it indicates that a person has delegated the responsibility to their relative to act on their behalf. The care records we viewed contained no evidence to show this authority was in place, nor any assessments of mental capacity. This information is essential to ensure that decisions made on behalf of people are lawful.

A member of staff we spoke with was not confident with the Mental Capacity Act 2005 or with the rules around consent. When we asked about obtaining consent from an individual the care worker told us they would ask the person to sign if they could, or "a member of the family". The service was not assessing and documenting, where necessary, people's ability to consent to care.

This was a breach of Regulation 11 (1) and 11 (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service caring?

Our findings

People we spoke with told us that staff were very caring and professional in their daily work. "They are all very good to me," one person told us. "They do over and above," said another. "Staff are kind and caring – I have no complaints at all," and "Staff talk to me like a friend. We have a laugh," were other comments we received.

A member of staff we spoke with at the service's offices? was passionate about the caring role. "I make sure I do it properly. They make my day as much as I make theirs," they told us.

Two relatives we spoke with referred to the care workers supporting their relations as being "like family." Some staff had established a strong rapport and built trusting relationships with the people they cared for on a daily basis but during our visits we saw that staff maintained professional boundaries.

We saw on one visit how the care worker and person using the service had mutual respect for each other. The person was asked if they required paracetamol for pain relief as this was an "on request" prn medication. The person accepted and a drink of water was brought for them and two tablets handed to them. They were then offered a choice of food for lunch. The person using the service deemed the care worker to be "excellent" and on being given the chicken soup they had requested, thanked the care worker and added, "That'll do me just fine."

The care worker kept busy, completing tasks and records during the visit but chatted and joked with the person all of the time. Before leaving they checked that the person had their safety pendant round their neck so that assistance could be summoned should an emergency occur. This demonstrated a caring nature and concern for the person's safety.

One person told us how their regular care worker did not turn up one day. They were sent a different carer for the lunch time call. "I didn't mind. [Care worker's name] was staying with someone else because they were ill," they told us. A member of staff we spoke with confirmed this. On arrival at a property they had found the person collapsed and called the ambulance, staying with them for over two hours until it arrived. This demonstrated that care staff knew how to respond to an emergency and were caring in their role.

Another person spoke very highly of her regular care worker. "Nothing is too much trouble," they told us. There had been an occasion when the person had wanted a particular meal at tea time and told us the care worker had gone out to get it for them.

Care workers treated people with dignity and respect. "[I] don't feel any embarrassment," one person told us and "Yes – they do treat me with dignity," and "Of course they do [treat me with dignity] - I treat them with dignity too." A relative added that staff were respectful to the person and other members of the family. Staff we spoke with provided us with examples of how they maintained a person's dignity and offered respect. They told us about closing curtains and doors before providing personal care and making sure people were covered up as much as possible whilst personal care was provided.

Staff supported people and encouraged them to be as independent as possible. One member of staff indicated that they would always ask the person if they needed help. "I always check with them. They might want to do it or try." This was supported by what a person using the service told us. "[They] let me do what I can," they told us whilst another person added, "If I need them they are there."

As part of our inspection we visited the offices of Age Concern. We found that electronic and paper documents were stored securely and the appropriate checks were in place to ensure that confidentiality was maintained for the people using the service. Staff handbooks contained a policy on the use of information technology including social networking sites. No work related issues or material that could adversely affect the company was acceptable for inclusion on any of these sites and staff we spoke with confirmed they were aware of the policy.

We saw that a person using the service had been signposted to an advocacy service. An advocate had met with the individual, discussed the situation and took their opinions to a Best Interest meeting, which the person chose not to attend.

Requires Improvement

Is the service responsive?

Our findings

Management of Age Concern undertook visits to people prior to them receiving a service and carried out an initial assessment of need. We could see that information had been gathered from a variety of sources including commissioners of care, the individual and relatives prior to care visits being undertaken. This was to ensure the service would be able to meet the person's needs. The manager emphasised that the service did not take on packages unless staff were available and the particular needs of the person could be safely met.

One person we spoke with told us, "I don't have to tell them. They just know what needs doing." People told us the service was able to respond to requests they made to vary or alter the timing of the visits, for example if they had a hospital or other appointment. "I tell my carer and she sorts it out," one person told us. Another person explained that care visits were not always needed as a relative was able to help during holiday time. When this happened the service stopped the visits for the specified period of time and restarted them when needed. This showed us the service was responsive to people's individual requests.

We saw a good example of person centred care in the recording of a lunch time visit. This was on archived sheets stored in the office and related to a visit undertaken to a person in January. The care worker had written, "wanted pork and stuffing on a warbies thin and a satsuma." We visited the person receiving the care who told us it was their favourite meal and the care worker knew this. The entry described exactly what the person preferred and was given, rather than the stock entry of "sandwich provided for lunch." It meant that the care worker recognised the preferences of the person, provided a personalised approach and it informed other staff who might visit in the future.

We viewed five care plans at the service's offices and also looked at care plans in people's homes. Care plans were basic and were mainly task orientated. There was little evidence that people had been consulted around their likes, dislikes and preferences. Whilst we were assured by people and their relatives that they considered the service to be good and regular care staff knew what was required, likes, dislikes and personal preferences should be documented in care plans. In the event of new care staff being introduced to an individual or "standing in" for a regular care worker, it is important that this information is documented so that the care and support they provide is personalised, safe and correct for the individual.

We saw that reviews on care plans had not been carried out for some time and that the information contained in them was not only incorrect but potentially unsafe. One person we visited was documented as requiring help with lunch time medication. On looking at the blister pack the lunch time medication blister was empty and the person told us that this had been stopped some time ago. The care plan had not been updated to reflect this although the person told us that care staff were aware medication was no longer administered during the visit. If a new care worker visited this person at lunch time however, they would be misinformed and may attempt to administer other medication based on the instructions in the care plan.

The lack of reviews and out of date information contained in care plans constituted a breach of Regulation 17(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to

17(2)(c).

On speaking with the registered manager, they recognised that care plans needed to be reviewed and to be more person-centred. We saw no personal profiles on the files we looked at. The registered manager told us there were plans to introduce "This is Me" paperwork that would provide care staff with a brief history about the person's life, including things that were important to them. This again would provide staff with information about the person, their interests, whether past or present, and could result in more meaningful care and support being provided.

The service had an up to date complaints policy and procedure. People we spoke with told us they were aware of the policy, knew how to complain and would have no qualms in raising concerns with the manager. A relative we spoke with had not made a complaint in the two years they had been using the service. "I've never needed to; [there's] nothing wrong with anything." They confirmed they had the contact number of the agency if they needed to complain. A second relative told us they had not formally complained but had left a note for care staff regarding the untidy state the kitchen had been left in on one occasion. "It's been ok since," they told us.

We saw that one relative of a person receiving a service had raised a formal complaint in 2015. This had been dealt with appropriately, documented and notes made on an electronic system under the individual's record.

Requires Improvement

Is the service well-led?

Our findings

Staff comments about the service were positive and all staff we spoke with felt supported by senior colleagues and the registered manager. "The agency is well run," a member of staff told us. Another said, "Communication is ok; there is an on call system and you can report any concerns." One thought the service was excellent to work for. "I would have gone elsewhere if not," they told us.

Staff were given a handbook following induction and this contained information pertinent to their employment. The handbook also contained copies of company policies including, for example, those on whistleblowing, the protection of vulnerable adults, confidentiality, lone working and health and safety. Staff we spoke with confirmed they had been given a copy of the handbook, which had been last updated in June 2014.

Staff meetings were held and were well attended. The service had taken a new approach to staff meetings in 2015, holding two meetings at different times on the same day covering the same agenda. Staff could then choose which meeting they attended, depending on the most convenient for them with regards to work pattern and other commitments. Staff told us they felt they were able to put their views across to seniors and to management and we saw examples of this from minutes of the staff meetings.

At the end of meetings, care staff were asked if they had any comments or questions they wanted to raise. A member of staff told the group they had turned up to provide care for a person who had been taken into hospital. The relative had not been able to contact the person on call over the weekend. The care worker brought this issue up during a staff meeting and felt comfortable in doing this with the manager present so that they could take steps to make sure that it did not happen again.

Other types of meetings included catch up meetings and one to one supervision sessions with members of staff. Staff told us they felt comfortable raising any personal issues or concerns in these sessions. The manager operated an open culture and was approachable we were told. "If something is wrong, I can say," a member of staff told us.

At the time of our inspection, the company did not have a uniform policy. When delivering personal care the policy was smart dress code for care staff. Care staff from a particular area had expressed a wish to wear uniforms. Management had taken this on board and we saw that uniforms had been ordered. The manager, in consultation with staff, had opted for black tunics for supervisory staff and lilac tunics for care staff. This meant that people receiving the service would be able to identify staff and the different roles they had in the service.

The manager of the service told us that they felt supported by the wider network of colleagues in the larger company of Age UK. They told us they were able to draw on the knowledge and expertise of senior colleagues and were supported on the second day of the inspection by the Area Manager.

As part of the inspection we asked the registered manager how the service was audited for safety and quality

and how improvements were identified and implemented. We were told about the traffic light system that the service had adopted. This was a practical tool that audited current competencies and highlighted areas where any additional training was needed.

Spot checks had recently been implemented by the service and staff we spoke with confirmed that these were being undertaken by supervisors. During our inspection however, there were no completed spot check forms available to evidence that these had been done. By the end of the inspection a formal recording mechanism was in place. This indicated that care staff were being observed during spot checks in a number of ways, including showing respect for the service user; respect for property; politeness and consideration and also in their ability to carry out care. Training needs were audited by the training co-ordinator and where any were identified these were notified to the manager.

When we asked the registered manager we were told there were no formal audits regarding the administration of medicines, recording of care or the duration of care calls. Our visits to people's homes highlighted that staff were not always recording daily notes and the administration of medicines accurately on the correct paperwork. We saw that old paperwork had been collected from people's homes and archived at the office but no audits had been undertaken on the quality of the recording and completeness of records. This meant that any issues and errors with these had not been identified and had therefore not been rectified.

At the time of our inspection, the service did not have an effective system in place to monitor and assess the quality of the service. This was a breach of Regulation 17(1)of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, with reference to 17(2)(a).

A number of people who received a service told us they had completed a questionnaire in 2015 about the quality of care they received. Prior to the inspection, the Care Quality Commission had also asked people using the service and staff for their opinion about the quality of care and other aspects of the service. Over 90 per cent of people who responded told us they would know who to contact at the agency if they needed to. "I've met the manager," one person told us. Another relative told us they would have no issues in raising any concerns with the manager.

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 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people must only be provided with the consent of the relevant person - with reference to 11(1). Capacity assessments had not been undertaken and the service was not operating in accordance with the Mental Capacity Act 2005 - with reference to 11(3)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Risks to the health and safety of people had been assessed but there was insufficient instructions on how to mitigate those risks - with reference to 12(2)(b) Not all administered medications were being accurately recorded. It was not clear what action had been taken about missing medication. Records were not updated in a timely manner following changes to people's prescribed medication - with reference to 12(2)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had introduced spot checks but formal audits of the service were limited.

Systems were not in place to fully assess and monitor the quality of the service and therefore improvements had not been identified - with reference to 17(2)(a)

Care plan reviews had not been carried out for some time and therefore information in some of these in relation to the service was out of date - with reference to 17(2)(c)