Sevacare (UK) Limited

# Mayfair Homecare - Wycombe

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

| | |
|---|---|
| Is the service safe? | Good |
| Is the service effective? | Good |
| Is the service caring? | Good |
| Is the service responsive? | Good |
| Is the service well-led? | Requires Improvement |

# Summary of findings

## Overall summary

The inspection took place on the 29 and 30 January 2018 and was announced. The location was previously inspected in June 2016. It was not in breach of any regulations of the Health and Social Care Act 2008 at that time, however they received an overall requires improvement rating. This was a comprehensive inspection to review the progress made and rating since the previous inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults. At the time of the inspection they were providing a care package to 180 people whose contract of care was sub- contracted to them from another two agencies.

Not everyone using Mayfair receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

The agency 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.

At the previous inspection in June 2016 the service was rated as requires improvement in all domains, with an overall requires improvement rating. At this inspection we found the service provided safe, effective, caring and responsive care. The service had a committed registered manager who had made the improvements to the service. However, the lack of an electronic logging in and out system meant there was a delay in auditing if all of the care calls had been provided which has resulted in a requires improvement rating for well- led.

Staff schedules were planned in geographical areas to cut down on travel time between calls and in an attempt to reduce delays between calls. The registered manager and staff from the agency felt confident no calls were missed. However, records were not always completed to support this and some people told us they had experienced missed calls.

People were asked for feedback on the service to improve practice. The registered manager and the provider audited the service to satisfy themselves the service was running effectively. However, the task of manually auditing communication sheets for the previous month meant that gaps in care calls were not highlighted and brought to their attention in a timely manner to ensure people got the care calls they required.

Some people were happy with the care provided. They had positive relationships with staff and described staff as kind, caring, excellent, helpful and accommodating. One person described staff as like friends to them. Other people told us that the times and reliability of the calls could improve.

Systems were in place to safeguard people. Risks to people were identified and managed. People were assessed prior to the package of care commencing. They had support plans in place which outlined the support required at each call. The support plans were updated and reviewed in response to people's changing needs.

Medicines were safely managed with people supported and enabled to self-medicate where possible. Staff were clear of their responsibilities in relation to medicine administration.

People's privacy and dignity was promoted. Staff were respectful of the person's home and their environment.

Staff were suitably recruited, inducted, trained, supervised and supported. This enabled them to have the right skills and training to support people effectively. Staff felt they worked well together as a team to ensure people got their required care calls.

People and their relatives knew how to raise concerns. They confirmed the registered manager was responsive to issues raised by them to offer a resolution.

The registered manager was a positive role model to staff. They provided hands on support when required. They addressed poor practice and was committed to providing the best care to people. They were instrumental in bringing about the improvements to the service but also recognised the challenges that they faced in managing a domiciliary care service.

## The five questions we ask about services and what we found

We always ask the following five questions of services.

### Is the service safe?

Good

The service was safe.

People were safeguarded and risks to them were identified and managed.

People were provided with staff, although not always at the times agreed to meet their needs.

People's medicines were appropriately managed.

### Is the service effective?

Good

The service was effective.

People were supported by staff who were inducted, trained, supervised and supported.

People were supported and enabled to make decisions about their day to day care within the principles of the Mental Capacity Act 2005.

### Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

People's privacy, dignity, independence and respect was promoted.

### Is the service responsive?

Good

The service was responsive.

People had support plans in place which outlined the care required at each call.

People were provided with information on how to raise a

concern or complaint.

## Is the service well-led?

**Requires Improvement**

The service was not always well-led.

People's records were not suitably maintained in that some communication logs were not completed to confirm if people had received their care call.

People were given the opportunity to feedback on the service. Systems were in place to monitor practices to safeguard people and make improvements to the service. However a robust system was not in place to audit that care calls had taken place in a timely manner.

People were supported by a registered manager who was committed to bringing about improvements to the service.

# Mayfair Homecare - Wycombe

**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 29 and 30 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit. This was because it is a domiciliary care agency run from an office. We needed to make sure that appropriate staff and managers would be available to assist us with our inspection.

The inspection was carried out by two inspectors who visited the office location on both days of the inspection. Two experts by experience who made telephone calls to people and their relatives prior to the visit to the office. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care services for example a domiciliary care service.

Prior to this inspection we reviewed the Provider Information Record (PIR). The PIR is a form that the provider submits to the Commission which gives us key information about the service, what it does well and what improvements they plan to make. We reviewed the previous inspection reports and other information we held about the service such as notifications they had sent to us. We contacted other agencies who sub contracted work to the agency to obtain their views about the care provided.

During the inspection we spoke with the registered manager, a care coordinator, a team leader and eight care staff. We visited four people in their own homes on day two of the inspection and spoke with nineteen people and seven relatives prior to the inspection. We spoke with a further two relatives after the inspection.

We looked at a number of records relating to individuals' care and the running of the service. These included seventeen care plans, medicine records for eight people, seven staff recruitment and supervision files,

accident/incident reports, audits, complaint's log, staff schedules and team meeting minutes.

We asked the provider to send further documents and policies after the inspection. The provider sent us documents which we reviewed and used as additional evidence.

Good

# Is the service safe?

## Our findings

At the previous inspection in June 2016 this domain was rated as requires improvement. This was because of the varied feedback from people using the service about the safety and reliability of the service provided at that time.

At this inspection we received mainly positive feedback on the service. People told us they felt safe with the carers. They commented, "Yes, I would happily leave things in front of them", "Yes, I would say it's safe in terms of the carers", "I feel safe; I do not feel intimidated by them being here at all" and "I don't feel uncomfortable when they are here. It all feels very safe."

Staff were aware of their responsibilities for reporting accidents, incidents or concerns. The provider had safeguarding adults and accident and incident policies in place. These provided guidance to staff on their responsibilities in relation to safeguarding adults and managing accidents and incidents. Accident and incidents reports were completed and where appropriate this triggered a review of the person to reassess any change in needs. Staff had been trained in safeguarding adults. During discussion with us staff demonstrated a good understanding of what abuse was. They were aware of their responsibility to report poor practice or concerns that put people at risk. A staff member told us they were up to date with safeguarding training. They gave an example of a form of abuse "physical" and signs that might cause concern "bruises on a service user which we should notice". They said, "We do call the office and inform them straight away. We document everything in the book (communication sheets)." They added, "Any sores, I do report." The staff member told us this would include any redness of the skin. Another staff member told us that, in the case of a fall, if a service user was "on the floor" they would "call 999 first". Staff we spoke with were aware of the whistleblowing policy. "If you see something that's not right" and the need to report this. They would "tell (the manager)". Another staff member told us they would report concerns, "My first priority is the client. That could be one of us one day."

The staff schedules were organised so that staff were working in one geographical area to cut down on travelling time between care calls. Staff told us their rotas were manageable and allowed them travel time between calls where this was required. They commented, "Generally my calls are all within close proximity to each other" and "The rotas are very organised, runs of people who live nearby." Staff told us sometimes they were asked to take on extra calls if a staff member went sick or they have been delayed on a call. They felt they worked as a team and therefore were willing to help to ensure people got their required calls. The agency had an out of hours and back up on call system in place. Staff told us on call support was accessible and responsive which enabled them to get the support they needed. Staff told us that there were no missed calls. A staff member commented "(the manager) is always on the phone" and "will always answer and find a solution".

If a call was going to be late, people were informed. Staff said, "We call the office. They call the service user." Another carer told us there were "no missed calls". If a call was going to be late, they said, "We'd phone the office or on-call." The staff member added, "We apologize" if late. They told us that clients were "very good" and would say "we understand."

Some people were not sure what time they should get their call, how long each call should be or how many calls a day they should get. The detail around the length of the call and number of calls was recorded on people's care plan. However, we saw from completed communication sheets the time and length of the care calls varied each day. Some care calls were close together and some care calls were not recorded as having taken place. The registered manager told us some people and their relatives agreed the times directly with the staff members. This was discouraged and the staff member or person is supposed to let the office know. Other people are flexible about when they get their call and some people cancel calls. A person's electronic log record provided after the inspection evidenced that one person regularly cancelled calls. The person suggested they wanted the flexibility of four calls a day but a review had not been requested with the funding authority or the contractor they had sub contracted from to agree a revised plan of care.

Some people told us they always got their call and at the time agreed. Other people told us the staff came but "may not be when I am expecting them". One person told us they had a missed call recently where no one turned up and they did not receive a call from the office. They commented, "This was the second time this year and if my relative is not here, I can't get out of bed on my own. Luckily my relative had already got me up before they went to work." This was fed back to the registered manager to look into.

One person told us they repeatedly requested the night calls to be after 8pm, and said, "My only complaint is they are sometimes too prompt. I don't like to be put to bed too early". They added, "[Staff member's name] always leaves me till last as she knows I don't like to go to bed too early". The registered manager told us that people were informed at the time the package of care was agreed what time calls the agency can offer which was not always what the person wanted. The registered manager commented "People then tend to negotiate that with staff which is why it is not a regular occurrence."

Some people told us staff seemed to have the time provided to carry out the care required. People commented, "Staff do not rush me and stay for a chat, some of the staff I consider to be my friends" and "If a staff member has a minute, they will sit and talk to me for a few minutes before she [staff member] goes home. One staff member makes my bed up". Others felt some staff were rushed. They commented, "If it is a quick wash- a lick and promise- they can be gone in 20 mins. If I have a shower, it's longer. I think they should stay about 45 mins but don't" and "Thursday or Friday last week, my carer had to rush me as they had twelve clients to provide care to." People added, "My care plan book says should have 40 mins care but don't get that. They [staff] said all their people have 20 mins care. Bills come through, all exactly the same, whether they [staff] came or not. I cancelled a day with plenty of warning but ended up still paying". These incidences were fed back to the registered manager to address and follow up on. The registered manager sent us copies of reviews with individuals carried out after the inspection. None of the issues raised with us about their calls were identified and the people indicated they were happy with the care they received.

People were assessed by the agency following a referral to them. The assessment identified people's physical, medical, health, psychological and personal care needs and support required. People's preferences and cultural needs were identified as part of the assessment process. People who required it had a moving and handling assessment in place which outlined the number of staff and equipment needed to safely move a person. A general risk assessment was completed which identified personal and environmental risks to people and staff. A risk management plan was in place which outlined how the risks were to be managed. These were more generic as opposed to person specific for example risks associated with diabetes or a mental health diagnosis were not identified. This was discussed with the registered manager and risk assessor who agreed to make the suggested changes.

People were provided with equipment to promote their safety. Some people had pendant alarms for emergency use. A person commented, "I've used it once. It makes me feel safe." Another person, who was

wearing a wrist alarm, told us a relative had told them it would help their safety, "I don't think I've ever used it." Some people chose to use the 'keysafe' system that allowed carers access to a house key via a secure, coded box. This meant a carer could enter the house even if the person could not reach the front door. Two of the four people we visited at home used this system.

People's care plans outlined if staff were administering their medicines. People consented to staff administering their medicines. A medicine risk assessment was in place to identify and manage risks associated with individual's medicine administration. A record was maintained of individuals prescribed medicines, where stored and who was responsible for ordering their medicines. The organisation had a medicine policy in place which outlined staff's role in medicine administration. Staff were trained in medicine administration and were clear of their responsibilities in relation to promoting safe medicine administration. Staff only administered medicines from a dosette box which had been filled by a pharmacist. A dosette box is an individualised box containing medicines organised into compartments by day and time, so as to simplify the taking of medicines. The majority of the medicine administration records (MAR) viewed were signed to confirm people had received their medicine. Three people we visited at home received support with medicines. These were prepared in weekly multiple dosage system (MDS) packs according to time of day. Their medication administration records were appropriately completed.

Systems were in place to manage infection control. Staff were trained in infection control and had a good awareness of their responsibilities in relation to infection control to prevent cross infection. They confirmed they were provided with ample supply of disposable gloves, aprons, face masks, sleeve and shoe covers to prevent the risks of cross infection. During the inspection care staff came to the office to pick up supplies of personal protective equipment such as disposable gloves and aprons. A carer told us it was important to be aware "if we've got a cough ourselves" and to use a face mask. People confirmed staff always wear their uniform and carry disposable gloves with them. A person commented, "Carers always wear gloves and they use the 'foot' protection when they help me".

Safe recruitment practices were followed before new staff were employed to work with people. Checks were made to ensure staff were of good character and suitable for their role. Records showed checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults. The provider had followed good practice recommendations and reapplied for Disclosure and Barring service check on existing staff. Files contained an up to date photo, application form, completed medical questionnaire and interview assessment records.

Good

# Is the service effective?

## Our findings

At the previous inspection in June 2016 this domain was rated as requires improvement. This was because the feedback from people was that the service was ineffective at that time.

At this inspection people told us the staff were well prepared for their roles. A person we visited at home told us staff were "nice" and answered "yes" when we asked if staff were well trained. Another relative told us some staff were very good and knew exactly the support their family member needed. However, they commented, "Some staff did not have a clue and had no common sense". They gave an example where a staff member gave their family member their food to eat whilst lying down in bed. They confirmed they had raised it with the office staff at the time and it was addressed.

People were supported by staff who had access to training to develop the skills and knowledge they needed to meet people's needs. Systems were in place to ensure new staff were inducted into their role. New staff completed three day induction training. They worked through an induction workbook and completed the care certificate induction. The care certificate induction is training to ensure care staff have the required skills and competences for their roles. New staff worked with another carer in getting to know people and to familiarise themselves with the role. All new staff who completed their induction were provided with a staff handbook which outlined the key policies they needed to be aware of. A carer told us, "We have three days training here" including moving and handling, safeguarding and the Mental Capacity Act 2005. This was followed by "twenty hours of shadowing" which (the manager) "organises so you do everything". The carer confirmed they were up to date with their mandatory training. Another carer told us they had three days of training initially prior to a period of shadowing another experienced staff member.

Staff were aware of their role and responsibilities. They all felt suitably inducted, skilled and trained to do their job. All staff had initial face to face training in topics the provider considered mandatory. These included safeguarding of vulnerable adults, emergency first aid, health and safety, moving and handling, infection control, medicines management and equality and diversity. Alongside that some staff had training in pressure area care, catheter care and dementia. Training was recorded on a training matrix and highlighted when updates were due. The database used for scheduling staff on shift would not allow staff to be booked on a shift if any of their training had expired. This ensured all staff had the required training.

When we asked about supervision meetings, a carer told us they had these, "I can't remember how often but it is quite often." They told us they had supervision meetings but "not for a while". Another carer told us "I haven't had one." However, staff told us they felt suitably supported and received one to one supervision sessions with the care co-ordinators or the registered manager.

The organisations policy on supervision outlined that all care staff will have a minimum of three supervisions a year and an annual appraisal. Alongside this care staff had an annual assessment of their role which is an observed supervision of their practice. Records viewed showed staff were being supervised, assessed and appraised in their role. New staff had probationary reviews before being signed off as permanent. The probationary period was extended where this was required. The provider had a matrix in

place to audit staff supervisions. The most recent audit for this location showed that 99% of staff had up to date supervision and appraisals. 100% of staff had a carer assessment and spot checks completed.

Systems were in place to promote communication within the agency. Staff were encouraged to report changes to individuals to the office. The office staff informed the care staff of changes to calls and new clients. The registered manager sent memos to staff to inform them of key changes within the agency. Staff told us they felt well informed and communication between them and the office was good. Some people told us communication with the office had improved in recent months. A person commented, "They are so pleasant over the phone but.... I haven't got any complaints at the minute and don't want to rock the boat now."

Staff were not actively involved in managing people's health. They liaised with other professionals such as the GP and district nurses to report changes in individuals. One person told us they would like to be able to have a shower. The registered manager told this individual had previously been assessed by an Occupational Therapist and it was considered not a viable safe option then. They agreed to refer the person back to Occupational Therapy. .

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.

Staff told us that they had taken training in Mental Capacity Act 2005 (MCA) and the accompanying Deprivation of Liberty Safeguards (DoLS). Carers we spoke with showed a good understanding of consent. A carer told us they always asked people, "Would you like to have a wash or a shower?" They added that people almost always preferred to have a shower. Another carer we asked about this legislation could not recall details, however they were aware of the presumption of capacity. When asked 'Who gives consent for an adult?' the carer replied, "The adult themselves."

People's support plans outlined if they had capacity to consent on their care and if not who acted in their best interest. People had signed service user agreements and consent to care forms. People felt involved in their care and told us staff generally checked with them what they wanted done. In care plans, we saw that people expressed their preference for gender of carer to provide support. We also saw an example whereby a person did not consent to use of the electronic call monitoring 'I am not happy to give my consent'

People's support plans outlined the support people required with food shopping, meals and drinks. Some people required staff to visit them at meal times to support them to heat their meal or make them a sandwich. Others did their meals independently. Risks around mealtimes were identified and management plans were in place to manage the risks.

Good

# Is the service caring?

## Our findings

At the previous inspection in June 2016 this domain was rated as requires improvement. This was because feedback from people indicated staff were not always caring and their dignity was not always promoted.

At this inspection the people we spoke with were positive about the care provided. People commented the service was "perfect, no problem, so far I'm all right". They said, "I am totally satisfied and grateful" and "The carers are very good and quite reliable." They added that they would be happy with the carers, "As long as they are as nice as they have been." Another person told us, "Some are more punctual than others."

People described staff as caring. They commented, "The staff are wonderful I rely on them. "They are all polite and always friendly." "[Staff member's name] is excellent, she literally sees to my every need." "Lovely girls." "Nothing is too much trouble for them, especially for the carers. I'm very grateful for what they are doing "and "They do a proper job, I think it's a very good agency." "I have been very happy with the carers." "The carers are very kind and willing to do all the things that I need them to do. They always say 'is there anything else?' before they go." "They are very helpful and very accommodating" and "They know my relative and just carry on. Very helpful."

A staff member told us, "You normally have regular people on runs." There was "always someone that knows the clients. It's good quality care. My clients are happy with us." Some people told us they have regular staff, whilst others told us they did not have regular staff. A person commented, "The staff are always different". The provider audited the continuity of carers to people weekly which showed people generally had regular carers during the previous three weeks.

Most people thought they got the care they needed. All except one person thought they had a choice of male /female staff member if they wished. This was fed back to the registered manager who gave us an explanation as to why some people did not have a female staff member.

Everybody thought they were supported to do things for themselves to promote their independence if they wanted to. One person said, "Yes, some staff encourage me to wash myself."

The provider had a dignity in care policy. This provided a framework for staff on how they promote dignity to the people they support. People said staff were respectful of their home and privacy. They said they were called by their preferred name. During a home visit, we observed that staff respected a person's privacy and dignity when supporting with personal care.

The provider had policies, guidance and systems in place to promote people's confidentiality in line with the Data Protection Act 1998. People had consented to their information being shared with relevant people.

Good

# Is the service responsive?

## Our findings

At the previous inspection in June 2016 this domain was rated as requires improvement. This was because the feedback from people indicated the agency was not always responsive to their needs.

At this inspection we found people had care plans in place which outlined their needs and specific detail was provided around the care required at each call. The care plans were reviewed and updated as people's needs changed.

Care plans were comprehensive. The home care support plan stated very clearly how many visits were to be made each day, at what time and for how long. The tasks to be achieved, when and how were described in the support plan. For example 'check communication book' was to be completed at the 'start of every visit' by 'checking the communication book to see if there's been any change in the client's condition' and reading any 'messages or instructions'. Necessary equipment was identified and how many staff should help the person. The care plans we viewed in people's homes had been completed and were current. A relative confirmed care plans were available to staff. One relative told us "some staff don't bother reading the care plans and don't know the support required". This was fed back to the manager to reinforce to staff.

Staff did not support people with activities unless this was requested as part of the package of care the person required.

The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The organisation had a policy in place which outlined their responsibilities in adhering to the standard. People's assessment document outlined people's communication needs and indicated how they preferred the agency to communicate with them.

People told us they felt able to raise concerns or complaints about their care package. They confirmed the registered manager was responsive to complaints. A person we visited at home told us, when we asked about contacting the office, the provider's 'phone number from memory. People had this contact number which diverted to an 'on call' mobile number held by a senior staff member on the front of their care folders. Another person commented, "I had one problem with a carer but the office sorted it out".

Staff were aware how to respond to concerns or complaints. The provider had a policy in place which outlined the time scales for acknowledging, investigating and responding to complaints. The agency had received 12 complaints and 27 compliments for 2017. The agency had a log of complaints which showed complaints were acknowledged, investigated and responded to.

Senior staff told us that the service provided personal care for people receiving end of life care.
The care plan for people on end of life care made reference to the person's end of life wishes and indicated if a Do Not Attempt Resuscitation (DNAR) order was in place. Some staff told us they had received some basic training on end of life care and it was sufficient. Other staff told us they could do with more training in this

area. A staff member commented, "More in depth training on end of life care would be beneficial to me and the clients as it is such an important thing to get right for a person". This was fed back to the registered manager to address.

Requires Improvement

# Is the service well-led?

## Our findings

At the previous inspection this domain was rated as requires improvement. This was because the feedback from people indicated there was a lack of consistency in the management of the service.

At this inspection improvements had been made to the management and monitoring of the service. The provider had a database which monitored and audited staff training, supervisions and appraisals. These showed the location was consistently recording a high percentage of these being completed and in date. The registered manager, team leader and care coordinators carried out face to face monitoring visits with people and spot checks on staff. Records were maintained which showed people were generally satisfied with their care and staff worked in line with the providers policies. Audits were also carried out by the two contractors that Mayfair sub contracted from. People and staff were given the opportunity to feed back on the service. People completed annual surveys and team meetings took place. The PIR sent to us in April 2017 indicated they had intended to get staff and service user forums established. These had still not commenced. The registered manager told us people were reluctant to agree to a date to attend.

The provider had systems established to monitor and audit the service delivery. An annual audit of a sample of staff and people's files, health and safety and complaints was carried out by an independent person on behalf of the organisation. The most recent one was completed in May 2017. Alongside this an internal audit was carried in December 2017 by a regional manager from another area. We were informed the actions had been completed but there was no evidence these had been signed off to confirm completion. We noted both audits identified improvements were required to records management.

For some people staff used an electronic call monitoring (ECM) system. However, some people commented, "Staff don't use it to log in and out anymore." A carer told us that they preferred to log in and out of calls because "if something happens, it protects staff and the person." Some people declined to use the ECM system, for example if they did not wish carers to use their telephone. A record was present on the person's file to support their decision. Their calls in and out were logged on the communication sheets kept at people's home. However, the communication sheets viewed were not routinely completed and showed variance in the length and time of the calls. Not all calls required were recorded as being provided. The electronic file note indicated some calls were cancelled by people but an electronic file note was not maintained for all gaps in the communication sheets viewed to outline why the call did not take place.

The agency's audits of communication sheets carried out by the care coordinators had not addressed the gaps in people's care calls prior to them being signed off and filed. The registered manager had discussed this with one of the care coordinators in their one to one supervision. They had reminded staff at the December 2017 team meeting of the importance of completing the communication sheets and had sent a memo to all staff to reinforce this. After the inspection the registered manager confirmed there was an improvement in the January 2018 communication sheets that they had audited. They sent us a sample which confirmed that. The agency was providing a service to 180 people. However, only a sample of communication sheets were audited monthly and not regularly which meant there was no robust system in place to audit that the care packages required were fulfilled. Feedback from some people reinforced that

their contract arrangements were not always fulfilled. People told us, "Several times in the past carers have not turned up", "They are routine visits but as a rule they are pretty late", "They don't turn up sometimes" and "I'm not sure, when, not recently but not a long time ago either". They added, "They're often so late that I have no idea which formal times they are supposed to be here" and "They are due here at eight o clock in the morning and at midday but they are often much later".

The provider confirmed they had introduced a mobile technology system in other locations which enabled staff to log in and out of people's homes. This also allowed staff to access people's care plans and medicine records remotely which would enable them to have access to up to date information on people. This needed to happen as a priority for this location to enable the provider to satisfy themselves that people were getting the care they required and any gaps in calls could be picked up In a timely manner to promote people's safety.

The registered manager was aware of their responsibilities under the Health and Social Care Act 2008 to notify CQC about significant events. We used this information to monitor the service and ensure they responded appropriately. The registered manager was initially unable to explain to us what the Duty of Candour meant. However, in discussion with them they indicated they understood their responsibilities to be open and transparent and inform people when something goes wrong that has the potential to cause harm. The provider had a duty of candour policy and guidance in place. The guidance included a letter template to be used to guide staff on what needs to be included within the letter to a person and/or their next of kin to inform them of an incident that falls within the duty of candour.

Some people were aware who the registered manager was. They told us the registered manager came to chat to them about the service. Other people told us they did not know who the registered manager was. They commented, "No I don't know the Manager though someone does come around once a year" and "No, I don't know the Manager and no one has been out to see me". Some people were happy with the office staff and felt calls to them were answered and issues addressed. Other people and their relatives were dissatisfied with the office staff. They commented, "If you phone the office and administration staff you are probably wasting a phone call". "Their admin is off the scale bad" and "I'm not happy with them at all". "It is not rocket science to get phones answered and calls to be made on time". "The office is the problem". "If I phone it is often not answered, once I tried it for eight minutes" and If you ring them to try and cancel a call you might as well speak to a brick wall". "Three times I've known carers come even when I had rung up to cancel them". This was fed back to the registered manager who told us they were in regular contact with people, they personally carried out the monitoring visits and issues within the office had been addressed. They felt some of this feedback from people may relate to their experiences prior to them taking over as registered manager.

A relative told they liked the registered manager. They described her as "A nice lady who gets things done". They were dissatisfied with the care coordinators, one whom they described as "always feel like they [staff member's name] fob me off". This was fed back to the registered manager. Staff felt the agency was well managed. They described the registered manager as accessible, approachable, caring, understanding and helpful. They felt the management of the service had improved since the registered manager had been in post. This was because their schedules were better organised in geographical areas, they felt better supported and they felt they worked more as a team. Staff told us the registered manager was very involved in the day to day running of the agency and they helped out with care calls if and when required. Staff valued that support.

The registered manager was committed to providing the best care to people. She was responsive to feedback from people to improve the service. She was involved in carrying out monitoring visits to people

and responded promptly to issues raised by them. The registered manager indicated their vision was to provide a quality service where staff and people who used the service were happy and safe.