Hales Group Limited

Hales Group Limited - Lowestoft

Inspection report

First Floor, 1-3 Beach Road
Lowestoft
Suffolk
NR32 1EA

Tel: 01502530676
Website: www.halesgroup.co.uk

Date of inspection visit:
13 December 2017
20 December 2017
04 January 2018
11 January 2018
15 January 2018

Date of publication:
28 March 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Inadequate**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The service provides personal care to people living in their own houses and flats in the community. At the time of the inspection the service was supporting 230 people. The service was given 48 hours' notice of our inspection because the service provides a domiciliary care service and we needed to know that someone would be available. Hales Group Limited – Lowestoft is a domiciliary care service located in Lowestoft, Suffolk predominantly providing care to people in their own homes in Norfolk and Suffolk.

This announced inspection took place on 13 and 20 December 2017. On 13 December we visited three people, with their permission, in their own homes and the office location. On the next three dates we spoke with people by telephone in their own homes. This was the first comprehensive inspection we had undertaken at this location since the service was registered at this location with the Care Quality Commission (CQC) in January 2017.

There was a registered manager in post. 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 and their relatives raised concerns with both late and missed visits. The care visit monitoring system was not effective to check if allocated visits were being completed as required and that staff were on time. Missed visits had also occurred, with family members being required to deliver care and this included personal care.

Staff had not always been deployed effectively to provide people with the support they required to meet their assessed care needs. During times of higher than expected staff sickness the senior staff managing the on-call service had not been able to meet everyone's needs, despite attending care visits themselves. The result was late calls when staff arrived up to two hours late or missed calls when staff had not attended.

People did not always receive support to keep them safe. The late and missed visits meant that people were at risk of not receiving meals, medication or assistance with personal care.

Each person had a care plan and risk assessments were in place. Staff had received training in the administration of medicines. A duplicate copy of the records was maintained and kept securely at the service office. People's care plans had been updated following changes to people's care needs and reviews of their care.

Staff had received training in order that they had knowledge to meet people's assessed needs and were supported with an appraisal and supervision.

Staff provided support to people to eat and drink as stated on their care plan. This included assistance with

food preparation and providing people with snacks and drinks between calls.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People informed us the staff were kind and caring. Staff provided understanding to people when providing care but the service overall did not demonstrate that they cared for the people they supported at all times because of late and missed care call visits.

The service sent satisfaction questionnaires to people who used the service and their relatives, asking them for their views and opinions of the service they received.

There was a complaint's procedure in place, this procedure enabled people to state if they were unhappy with the service. The people we spoke with were aware of how to make a complaint. The service also collated positive compliments that had been made based on people's experiences.

The service had quality assurance systems in place that were not working well. The registered manager had introduced a new system for monitoring staff sickness in order to support staff and in time reduce staff sickness. The registered manager had also investigated and identified reasons for a number of late and missed visits in September 2017 and put into action monitoring the care co-ordinators workload to support them with their work.

We found a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Inadequate

The service was not safe.

Planned care visits were late or missed and people were not always informed of this.

Staff were not always deployed effectively to provide the support people required.

The visit monitoring system was not effective so management could not fully demonstrate oversight of late and missed visits.

Because of the missed and late care visits we could not be sure people always received their medicines as prescribed.

The service has a process for learning lessons when things went wrong but lessons have not been fully learnt.

Is the service effective?

Requires Improvement

The service was not always effective.

Late and missed care visits meant the service was not always effective in meeting the assessed needs of people using the service.

Staff received supervision as part of their role. A staff induction was also in place which provided staff with an overview of working for the service.

Service staff worked with other services to support people with their needs.

Is the service caring?

Requires Improvement

The service was not always caring.

Due to the shortfalls found within the service relating to missed and late calls, some people did not always receive the caring service they required.

People said their privacy and dignity was respected by staff.

Is the service responsive?

Requires Improvement

The service was not always responsive.

The service was not always responsive because of late and missed care call visits.

Care plans captured information about people's likes, dislikes and preferences.

We found verbal complaints were not always recorded and effectively resolved.

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Is the service well-led?

Requires Improvement

The service was not always well-led.

Auditing and quality assurance systems were not fully effective in identifying concerns and taking action to resolve the problem.

Satisfaction surveys were sent to people and some responses were positive. Further work was required upon areas where people considered the service fell short.

Hales Group Limited - Lowestoft

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 announced inspection took place on 13 and 20 December 2017 and 4, 11 and 15 January 2018. The inspection was announced and on the first day we visited the office location and three people in their own homes. On the other days we spoke with people by telephone in their own homes and staff at the local authorities responsible for placing and monitoring people's care contracts with the service.

The inspection team consisted of one inspector and two experts by experience who spoke with people who used the service and their relatives via telephone. An expert by experience is someone who has personal experience of caring for people, similar to this type of service.

Before the inspection, the provider completed 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.

Before the inspection we reviewed any information we held about the service in the form of notifications about any safeguarding or whistleblowing information we had received, previous inspection reports and any complaints about the service. This helped us determine if there might be any specific areas to focus on during the inspection.

At the time of the inspection the service provided care and support to approximately 230 people in their own homes. As part of the inspection we spoke with the registered manager, regional manager and four members of care staff. We spoke with 30 people who used the service and 12 relatives. This was to seek

feedback about the service provided from a range of different people and help inform our inspection judgements. We also looked at information sent to us from other stakeholders, for example the local authority.

During the inspection we viewed six care plans and three staff personnel files. We also reviewed other documentation relating to the running of the service, such as satisfaction surveys, complaints, spot checks/observations on care staff, policies and procedures, and quality assurance audits.

Inadequate

Is the service safe?

Our findings

We looked at the arrangements in place to ensure there were enough staff available to safely meet the needs of people. We saw that from 7 September 2017 to 26 December 2017 there had been a total of 30 missed visits. This meant that on 30 occasions staff did not attend at all to support people with their assessed needs. During this period there were also 46 late visits. The service arranges with the person a time for their care visits and there is an agreement the staff will attend 30 minutes either side of the allocated time. A late visit is defined by the service as when the staff attend but are more than 30 minutes late.

As a result of the late and missed visits one relative commented that they had to leave their work to provide the care and support to their relative. One person told us, "I need a great deal of care and when the staff come this is an opportunity for [my relative] to go out and have a life. When they do not come and they have missed four times in January already they [my relative] have to come back to look after me. They do not have enough staff, I do not get a rota and you never know who is coming."

Members of staff informed us that they were regularly asked to do additional visits and to work extra days. Staff felt obliged to do this although at times became very tired. A member of staff told us, "We do not have enough staff we keep recruiting but we do lose staff as well."

A relative informed us, "Fortunately I have a very understanding employer. [My relative] does not have a rota so we do not know who is coming. When the staff do not come, [my relative] will contact me and I will go and provide their personal care whether I am at home or from my work."

People informed us that when they had regular staff they had built up positive relationships with them to lead healthier lives and have on going healthcare support. A member of staff told us, "I work with the same people most of the time. We have got to know each other and it works very well." We were informed of a frustration by people when they did not know who was coming to care for them and had what they considered to be a large number of carers. A person told us, "It is better than it was I need to have the same staff not for me but because of the dogs. I do not want to have to explain again and again are the staff alright to come because my dogs are protective and wary of strangers."

The technology and equipment used by the service was not fully effective. The service supported some people with memory difficulties and they would not necessarily know if the staff were running late or did not visit them. Members of staff told us about the problems experienced with the call monitoring system. Staff explained to us that staff could telephone or send text messages when they arrived and left the person they were supporting. Not all staff were happy to use their personal mobile telephones for this purpose and there was confusion about reimbursed payment to the staff for text messaging. Some people objected to staff using their landline telephones and hence this was not always an option. Not all staff contacted the office staff regarding their work schedule so the office staff would not be aware if any allocated calls were missed or the staff were running late. This meant that monitoring where staff were and calls they had completed was not always effective.

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

People we spoke with gave us a mixed response about whether or not they felt safe using the service. One person told us, "My care worker is lovely and I trust them". Another person told us, "I do not always feel safe because they [care staff] do not come at all sometimes." Another person told us, "They [care staff] did not come one day. I can wash my top half but I cannot wash my bottom half and I had to sit in my nightie all day." These views were also expressed by relatives. One relative told us, "We have experienced a number of late calls when staff do come but within two hours of the allocated time." Another relative told us, "They did not come at all for one weekend, things improved and then they missed [my relative] again at another weekend. They do not always tell you they are not coming."

One person told us, "The office staff are rubbish, I have not had a carer this morning and not been informed why they are late or when they are coming. I cannot do anything for myself at present as I have [specific need] and I cannot get out bed. I would be so pleased to see them." We spoke with the registered manager at the time about this situation and learnt that a member of staff did attend to support the person a short time later.

We were informed by the local authority a person with a diagnosis of diabetes relied upon the service's staff for meals. They had a visual impairment and the late calls had led them trying to cook for themselves resulting in minor burns.

This is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.

We looked at how risks to people and staff were assessed and managed within the service. The service had undertaken environmental risk assessments in people's homes, which took into account fire safety and smoke alarms. One person told us, "They are very good. I have poor eyesight and they suggested some changes to reduce the trip hazards."

We saw in people's care plans there was a risk assessment and information provided about how to support people. When people required assistance with lifting and handling the equipment was specified and clear instructions were in place of how to support the person.

We looked at the systems in place regarding how to safeguard people from harm. We asked staff about their understanding of safeguarding and how they would recognise potential signs of abuse. One member of staff said, "It is not just physical abuse there are many others such as financial and we have training when we start with the service and every year about what to do." Another member of staff told us, "I would report anything to the manager but know I can talk with the safeguard people as well."

The service had a recruitment system in place. Appropriate checks were carried out before staff began working at the service to ensure they were suitable to work with vulnerable adults. During the inspection we looked at staff personnel files. Each file contained an application form and a record from the Disclosure and Barring Service (previously the Criminal Records Bureau) to determine if the potential member of staff had a criminal record preventing them from working at the service. There was evidence of references being sought from previous employers. These had been obtained before staff started working for the service and evidenced to us staff had been recruited safely.

Each person requiring medicines had an individual medication administration record (MAR) chart. The

charts we saw included information about allergies, the medicines and times for the medicines to be administered. The records we saw had been completed correctly. We could not be sure due to the missed and late care call visits people always received their medicines as prescribed. One person told us, "They apply my creams and eye drops and record that on a chart for me." We also noted that in people's care plans information about their medicines was recorded including why they had been prescribed. The care plan also stated when medicines were to be administered to support the information in the MAR.

Senior members of staff checked medicines records were completed as part of the spot checks and observation of staff. A member of staff told us, "We are trained to administer medicines when we join the service as part of the induction and then yearly training."

We looked at the systems in place with regards to infection control. We saw that staff received training in this area and it was also covered during spot checks of staff. The staff we spoke with said they had access to sufficient amounts of Personal Protective Equipment (PPE) such as gloves and could go into the office for additional supplies. A member of staff told us, "The training on infection control was informative."

Requires Improvement

Is the service effective?

Our findings

People told us that their needs were assessed and the service took account of their choices. One person told us, "My care plan is correct, all help is noted down and there is enough time for me. The staff never leave early or rush me." However, the number of late and missed calls meant that for some people they did not receive the care at all or they received it late. This meant that their assessed needs were not being met.

People informed us that when it was identified they required some support with their needs someone from the service visited to discuss if they wanted to use the service. Staff had recorded in people's care plans information with regard to decisions about how the care was to be provided. The registered manager explained to us that they and the co-ordinators tried their very best to fit around people with the times they wanted staff to visit. However in the first instance there could be a need for compromise and they would always have looked to move visit times with the person when this could be achieved. People and relatives we spoke with informed us that they were involved in decision making and the most difficult aspect was agreeing upon suitable times for the care visit. This was because the service was already committed to other care visits at the time the person wanted their care visit. The service staff offered alternatives times and did try to arrange care visits when the opportunity arose.

There was a staff induction procedure in place, which provided staff with an overview of working for the service and their role. The staff we spoke with informed us there was a detailed induction and training was provided before they commenced working with a colleague. The registered manager arranged for new staff to work with another experienced member of staff until it was agreed they were confident to work on their own. The induction training included dignity and respect, food hygiene, moving and handling, safeguarding, medicines, lone working, infection control and health and safety. One member of staff said, "I learnt a lot from the training and it did prepare you for going out and providing the care to people." The training matrix provided information about yearly planned training and this was confirmed by the staff when we spoke with them.

Staff had planned supervision and a yearly appraisal as part of their on going development. Supervision provides staff with the opportunity to receive feedback on their work and discuss aspects of their role in a confidential setting. Supervision was planned for three to four times per year and included a spot check. A spot check is when the supervision is not planned with the staff member and a senior person will observe their practice and provide feedback. Each member of staff informed us that they had received a yearly appraisal which related to their supervision and was an opportunity to discuss their career development.

The people we visited informed us that staff supported them by preparing meals of their choice and ensured they had enough to drink. We looked at people's care plans to determine how staff supported them to have and maintain good nutrition and hydration. The service supported some people by preparing meals and reminding or assisting them to eat and drink. One person told us, "They [care staff] know what food I like and prepare it for me." A member of staff informed us they were not recording any food diaries or fluid balance charts at present as they were not required. They were aware of how to do this and also informed us when preparing meals they made a note that the fridge and cupboards were stocked with choices. However,

one person required support with their meals due to a medical condition and the late calls by staff had meant that they did not receive this support at the appropriate times.

One person informed us they were very pleased with their care plan. They informed us about how the staff recorded information every day. They told us, "They do the things I ask and know my favourites. Last night they made my tea, it was chicken and chips and very good."

People's healthcare needs were detailed within their care plan. Appointments and outcomes with other services such as doctors and chiropodists were recorded in people's care plans to promote effective communication. A member of staff informed us how they had encouraged a person to contact their doctor and for another person they had made an appointment for them. The appointments had been made and information recorded in the care plan. A relative informed us that they arranged appointments for their relative and wrote this information into the care plan. The service had also worked upon a detailed summary of the people's support needs that could be used should the person need to go to hospital. This summary provided basic information to help other staff to support the person.

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 had received training and guidance in the MCA. The staff we spoke with had received MCA training and were clear should they have concerns about people's mental capacity to seek advice from the registered manager.

Requires Improvement

Is the service caring?

Our findings

People and their relatives told us that staff treated them with kindness and respect. One person told us, "The staff are ever so respectful in my home, lovely staff." A relative told us, "Do not blame the carers, they are fine no problem just not enough of them." Another relative informed us that because their relative lived with the person needing care and other relatives were living close by the service had not always sent two carers. Their view was that the service expected one of them to stand in which they considered wrong especially as personal care was required for each visit.

The service overall did not clearly show that care was shown at all times to all people they supported. The oversight of the service was not sufficient to have recruited sufficient staff to consistently meet people's immediate and on going needs. Although we found staff were caring and had good intentions people had not always received care and support in line with their assessed needs.

One person told us, "I have the same carer weekdays and another regular person at weekends works brilliantly. It has built up over ten years and those carers are always excellent. The problem arises if they are off sick or on holiday then it is a lottery."

We asked people and their relatives for their views and opinions of the care they received. One person said, "When they turn up they are great, but it is not the staff's fault, they are very good." Another person told us, "I feel for the staff, they apologise for being late, but they are covering for someone which is why they are late." Another person told us, "I did not mind when they were late once because they had stayed with someone poorly and that is caring."

The service had recorded information about people's equality, diversity and human rights needs and we found positive examples of these being taken into account. However, we were informed of one example when two male staff unknown to the person came to support a female person. The person and their family found this distressing as they required personal care and having male staff had not been discussed with them in advance.

People informed us staff treated them with dignity and respect when delivering care and staff demonstrated an understanding about how to treat people in this way when supporting people. One person told us, "They always draw the curtains to protect my dignity." A relative told us, "We always have towels available and [my relative] tells me they cover them over when providing personal care."

People told us staff promoted their independence where possible and included them in personal care tasks to see if there were things they may like to do themselves. A member of staff told us, "I make the toast in the toaster but leave the person to butter their own toast." A person told us, "The staff have helped me to stay independent as much as possible. I can wash myself but I need a hand in and out of the shower. I am sure they would wash me if I could not."

When we visited the service office we found private and confidential records relating to people's care and

support were securely stored in a locked office. People we spoke with told us they had a copy of their care plan given to them which they kept in their home. The care plans we saw in people's homes were in agreement with those we saw at the office. Staff were aware of the need to protect people's private and personal information. This helped ensure that people's personal information was treated with respect and confidentiality.

Requires Improvement

Is the service responsive?

Our findings

We were informed by a relative that they had contacted the service four times in a week and the verbal complaints had not been acknowledged. The person informed us that they would now write to the service to ask the service to respond to their complaints in writing.

Three relatives we spoke with considered the service was unreliable and informed us they had complained verbally and had been assured things would be resolved. The issues reported to the service were about either late or missed calls. They told us that all would be running smoothly for a month or so and then the problem of a late or missed visit would happen again. Relatives told us that they were not informed in writing of an acknowledgement of the conversation when they reported a complaint verbally. This meant that staff were unclear of the procedure to follow when dealing with a verbal concern and service users and their families did not always receive a written follow-up to them. As a consequence of this feedback the provider has confirmed to us that they will review their complaints policy and provide new guidance to staff

We looked at how the service managed complaints. There was a complaints policy in place and people who used the service and their relatives told us they knew how to make a complaint. The service policy on comments, compliments and complaints provided clear instructions on what action people needed to take in the event of wishing to make a formal complaint. People informed us they were given information when they first used the service about how to make a complaint. People said they would contact the office if they were unhappy with the service they received and many people felt appropriate action would be taken. We saw that the service had responded having investigated people's written complaints with a detailed answer including an apology.

One person informed us, "I have no complaints. I did have one carer I mentioned to the manager at review they tickled my feet and I got quite upset because it was not funny and was painful. It was a concern not a complaint but the manager never sent them back."

Staff monitored and observed the people they supported and worked with other services, including the GP, as required so people's needs were met. The service provided support to people with other services at a time recognised to be near the end of the person's life. Staff informed us of positive information of how they were able to support people and their families. This included staying with people when they were unwell until GP's or ambulances arrived.

People's care needs were assessed before they first began to use the service. Service staff were consulted by the person or information was provided in the form of an assessment of the person's individual needs by the local authority. This was to determine if the service could meet the person's needs. A member of staff then arranged to visit the person in their own home to complete a detailed needs assessment and learn about the person's choices. Once agreed arrangements were made for the support package to commence. This was dependent upon the service care co-ordinators looking at the staff availability to be able to provide the support required. Copies of the assessments were held within people's care plans at the service office.

Each person's care plan provided an overview of the individual's care needs, specific needs and risk assessments. People who experienced missed and late calls did not receive the support as stated in their care plan. The care plans were easy to read and follow with regard to the support required at each scheduled visit. Each visit with the maximum being four visits per day were clearly defined with a time allocated for the visit, the length of time it would take and number of staff required. We also noted outcomes people wanted to achieve were recorded as was any equipment that needed to be used. We saw care plans contained details about people's likes, dislikes and specific choices and instructions for their care. This meant staff had access to information of importance about people and their preferences.

One person told us, "My care has been reviewed and I fully participated in it." We saw in the care plans that reviews had taken place on a planned basis and if significant events had happened which required a change in the care plan.

Requires Improvement

Is the service well-led?

Our findings

The service call monitoring system was not sufficient to provide accurate information of whether care visits to people were being completed on time, were significantly late, or if a missed visit occurred. The service relied upon staff, the people who used the service or their families contacting the office to inform them of any problems such as missed or late visits. This presented the risk of people not always remembering to telephone the office if their care visit had not taken place, resulting in the service not being aware that people were not receiving the care they required. We had received concerns of late and missed care visits prior to our inspection. Although auditing of the care visits was being carried out the resulting action taken was not effective to resolve the problem of people experiencing late and missed care visits.

Four visits were missed on 26 December 2017 because a member of staff did not report for duty. The service only became aware of this after the event and hence the visits were missed and people did not receive the care they needed. We spoke with the registered manager who informed us that over New Year's Eve 2017 and New Year's Day 2018 no visits were missed. However, the local authority informed us that they were aware of two visits being missed and their own staff covered them to ensure people were receiving care. This meant the system to safely monitor and respond to missed and late visits was not operating effectively.

A relative informed us of the problems they had encountered regarding the on-call system. When people experience a problem with the service they can contact the on-call service to explain the problem and ask for help and how the service will resolve the problem. No carer had attended to their relative for half an hour after the allocated time of the care visit. They attempted to contact the service over the weekend and they told us they had to wait over half an hour to be able to speak to anyone about the problem.

A relative told us, "They do not learn from when things go wrong. They put it right for a time but then we have missed calls again." The registered manager compiled a record for each missed and late visit of which they were aware. They carried out an enquiry for more in-depth investigation to determine what had gone wrong and lessons to be learnt. The view of both the regional manager and registered manager was that additional management was required at the service. They were seeking to appoint a deputy manager to assist the registered manager but the position remained vacant during the time of the inspection.

We found the on-call arrangements were not sufficiently robust to support staff to meet the needs of people when the service experienced problems with staff sickness. A senior carer and care co-ordinator were available to stand in for staff that were absent to attend to people's allocated visits. However, when there were a number of staff off duty sick they could not cover all of the visits. When the on-call staff provided care themselves they could be contacted by mobile phone. This was not ideal as this interrupted the care visit. This also meant the on-call staff could not fully focus upon coordinating staff and resources.

The service was not effectively providing people with rotas to inform them of who was visiting to provide their care which caused some people distress.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

The registered manager was supported by a regional manager and an interim supporting manager for a short period. There were two care co-ordinators reporting to the registered manager and four field based supervisors. In total it was reported to us that there were 97 care staff. The deputy manager post was vacant and the registered manager continued to advertise for this post to be filled but the post remained vacant. Both the regional manager and registered manager viewed the high importance of this post with regard to managing the daily issues currently where the registered manager spent significant amounts of their time.

The registered manager told us about a new system in use to the service to support them to manage sickness better and to provide more support to staff with sickness and absence from work issues. Although staff sickness had improved the service had continued to seek more staff because the current staffing resource was under continued pressure to meet people's assessed needs.

The registered manager as a result of the problems experienced in September 2017 of late and missed visits had investigated the situation. They determined that too many allocated visits were not being planned in advance. The solution was to work more closely with the care co-ordinators on a daily basis in an attempt to plan allocated visits further ahead. This had proved partially successful with a reduction in missed and late visits and staff given more notice of their work schedule. This close monitoring of a small number of staff was not adequate in dealing with the issue of people having their care visits on time.

We looked at the systems in place to monitor the quality of service being provided. Satisfaction surveys had been sent to people who used the service and their relatives to seek their feedback about the service they received. One person informed us, "They do send out a letter and the head office comes out and reviews the plan and sits and chats to make sure all is fine. I would rate them as pretty good and score them nine out of ten."

The service had carried out a survey in the summer of 2017 when 66 people were contacted and responses had been received from 63 people. In answer to the 30 questions asked, 37 people had rated the politeness of the carers as excellent. The bottom rating was staff punctuality and of the 66 people asked poor was the rating of 14 people.

The registered manager informed us that from the survey they were trying to recruit additional care staff. They also stated, "We will not lower our standards we can only employ the right staff." The service was aware from the survey punctuality was of the most concern to people using the service but had not resolved the problem of late and missed care call visits.

Audits of the care plans and medicines administration records (MAR) charts were undertaken and unannounced spot checks of staff carrying out support in people's homes. The spot checks provided the opportunity for senior staff to see how care staff supported people and to provide feedback to them. It also gave the opportunity for senior staff to meet with the people and their relatives.

The service had policies and procedures including a whistle-blowing policy of which staff were aware. One member of staff told. "I am aware of the whistleblowing policy but never had to use it but would if I needed to do so."

During the inspection we became aware that the service was meeting regularly with Norfolk County Council to monitor the volume of missed and late calls due to the number of concerns that had been raised by people and their relatives.

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 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 HSCA RA Regulations 2014 Safe care and treatment Appropriate systems were not in place to ensure people received safe care and treatment.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA RA Regulations 2014 Good governance Appropriate systems were not in place to ensure good governance.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Regulation 18 HSCA RA Regulations 2014 Staffing There were insufficient numbers of staff employed to meet the assessed needs of the people using the service.