Agincare UK Limited

Agincare UK Southampton

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
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 2 and 3 October 2018. The inspection was announced which means that we gave the provider 48 hours' notice of the inspection to ensure key staff were available to speak with us.

Agincare UK Southampton is a domiciliary care agency that provides personal care, respite and domestic services to people in their own homes, some of whom will be living with dementia or have complex health needs. The service operates mainly in the Hythe and Totton areas of Southampton. Not everyone using the service received a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care', that is, help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided. At the time of our inspection, there were 61 people receiving a personal care service.

The service was last inspected in June 2017 when we found it to be in breach of Regulation 19, Fit and proper persons employed. The overall rating of the service was 'requires improvement'. Following our last inspection, the manager sent us an action plan with details of the improvements
they planned to make to meet the requirements of this Regulation.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) to manage the service. Like registered providers, they are registered 'persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Recruitment practices continued to require improvement. All the required checks had not been completed before new staff members started work.

Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed.

There were systems in place to monitor the quality and safety of the service provided, however these were not always effective.

People's care records lacked information relating to their support needs, although people told us, and we observed, that staff knew people well and knew how they liked to be supported.

People told us that their care workers were well trained and records confirmed staff had received training relevant to their role. However, some staff were not confident about how they would respond to an incident of choking. We have asked the registered manager to review the skills and knowledge of staff with regards to this.

Further improvements were needed to ensure that staff were following relevant policies and best practice

guidance on medicines management.

Staffing levels were sufficient to meet people's needs and overall people were satisfied with the reliability of the service.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect.

Incidents and accidents were appropriately recorded and used as an opportunity for learning.

The registered manager told us, no one using the service lacked capacity to consent to their care. We saw evidence of staff seeking people's consent before provided support and offering them appropriate choices.

People were supported with their health and nutritional needs.

People were treated with kindness and felt that their privacy and dignity was respected.

Complaints had been managed appropriately.

People and staff spoke highly of the registered manager, who they said was approachable and supportive.

During this inspection we found one repeated breach and one new breach of the regulations. This is the third consecutive time the service has been rated as 'Requires Improvement' and we are currently considering our response to this and will report on any further actions when all representations are concluded.

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 continued to be rated as requires improvement.

Recruitment practices continued to require improvement. All the required checks had not been completed before new staff members started work.

Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed.

Staffing levels were sufficient to meet people's needs and overall people were satisfied with the reliability of the service.

Incidents and accidents were appropriately recorded and used as an opportunity for learning.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect.

Is the service effective?

Good

The service remained good.

People's consent was sought when delivering care.

People told us that their care workers were well trained and records confirmed staff had received training relevant to their role.

People were supported with their health and nutritional needs.

Is the service caring?

Good

The service remained good.

People were treated with kindness and had developed positive relationships with their regular care workers.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service had improved to good.

People's care records lacked information relating to their support needs, although people told us, and we observed, that staff knew people and how they liked to be supported well.

Complaints had been managed appropriately.

Is the service well-led?

Requires Improvement

The service continued to be rated as requires improvement.

There were systems in place to monitor the quality and safety of the service provided, however these were not always effective.

People and staff spoke highly of the registered manager, who they said was approachable and supportive.

Agincare UK Southampton

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 was an announced inspection which took place over two days on 2 and 3 October 2018. The inspection team consisted of a one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who has used this type of service. The lead inspector visited the organisation's office and spent time speaking with the manager and staff. They also visited three people in their homes to obtain their views about their care. The expert by experience undertook phone calls to people using the service.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the provider tells us about important issues and events which have happened at the service. The provider had competed a provider information return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to help us decide what areas to focus on during our inspection.

During the inspection we spoke with nine people who used the service by telephone. During our visits to people in their homes, we spoke with two people and four relatives. We spoke with the registered manager and ten care workers. We reviewed the care records of six people and eight staff and other records relating to the management of the service such as audits, incidents and policies.

Following the inspection, we sought feedback from four social care professionals about their views of the care provided by the service. One of these replied.

Requires Improvement

Is the service safe?

Our findings

Overall people told us they felt safe when being supported by the care workers. One person said, "Definitely, without a doubt [I feel safe].

In August 2018, CQC and the local authority received information of concern which led to local authority safeguarding teams visiting the service to review in detail the robustness of risk assessments undertaken when new staff declared previous convictions or cautions as part of their recruitment process. The review identified areas where the recruitment process could and should have been more robust. In response the provider has undertaken their own investigation which has resulted in a number of actions. This included a nationwide audit of staff files and a review of policies and supporting tools such as risk assessment documentation. Managers are also to take part in a leadership quality review session specifically on risk assessment of decisions about recruitment where potential risks are identified following Disclosure and Barring Service (DBS) checks.

Our last two inspections in April 2016 and June 2017 had found that improvements were needed to ensure that appropriate recruitment checks took place before staff started working at the service. Whilst most of the required checks were in place, this inspection continued to find concerns. For example, in the case of five staff a full employment history had not been obtained. This information is important as it allows relevant background checks to be undertaken. The registered manager has since provided some evidence to account for these gaps, but the information was not specific and therefore did not provide satisfactory evidence of the staff members employment history. This is a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Fit and proper persons employed.

Risks associated with people's care needs needed to be more clearly documented and include plans for managing the risks. For example, one person had been assessed as having severe dysphagia and of being at risk of choking. Their eating and drinking care plan did not reflect these risks or identify that the person was at risk of choking. There was no guidance for staff on how to manage a choking incident. This was particularly important as the person was choosing to eat high risk foods and therefore their risk of choking was increased. The need for this person's care plan to be updated and made more robust had been identified on the 30 August 2018, but the provider's own auditing process, but no action had been taken to amend it by the time we inspected four weeks later. We were further concerned that two of the staff we spoke with did not provide an appropriate response as to how they should support a person who was choking. One staff member said they would 'tap them on the back and give them a drink' and a second staff member said they would 'lay them down on the bed to clear their airway'. These are not recognised first aid responses to incidents of choking. We have asked the registered manager to review the skills and knowledge of all staff who support people at risk of choking.

The falls risk assessments viewed were a little confusing and it was not clear from these which remedial actions were being taken as some information on the form was pre-populated. The provider's quality manager told us that this form was being reviewed to make it clearer which remedial actions were being taken.

Other risks were more clearly identified and managed. Care plans contained a general health and safety risk assessment which considered a range of environmental risks and how these might be addressed. Where bed rails were being used, risk assessments regarding these were in place. On an annual basis, or if there was a change in the person's needs staff completed a risk assessment regarding the person's risk of developing pressure ulcers or skin damage.

We looked at how the service managed people's medicines. Staff underwent training as part of their induction on the safe administration of medicines and also underwent an annual assessment of their competency to do this safely. Each person's care plan included a list of their medicines, which included additional information such as the strength of the medicine, the dosage and any special precautions. A medicines administration record (MAR) was used to record the medicines staff had administered. Where people took 'as required' or PRN medicines, protocols were in place which described when these should be used. Staff were clear about the action they would take in the event of a medicines error which included reporting this to the office and seeking medical advice. However, when reviewing a sample of MARs for August 2018, we noted that four of these contained gaps. A review of people's daily notes, indicated that staff had administered the creams or medicines in three of the four occasions, but they had not completed the MAR in line with the provider's policies and procedures. This is also not in keeping with current best practice guidance from the National Institute for Health and Care Excellence (NICE) which states that 'Care workers must record the medicines support given to a person for each individual medicine on each occasion'. Minutes of team meetings showed that the registered manager had been reminding staff of the importance of completing MARs fully and signing these immediately after the medicine had been administered. However, further improvements are needed to ensure that staff are following relevant policies and best practice guidance.

Staffing levels were determined by the number of people receiving a care service and the registered manager told us they would not take on additional calls unless they had the capacity to meet these. The length of visit and frequency with which staff attended to a person, was in most cases, determined by the local health and social care teams who commissioned most of the care being provided. People told us their scheduled visits were always provided, but some expressed frustration at not always knowing an exact time the visit would take place or which care worker would be attending. For example, one person said, "They [staff] are all good people…the only drawback is that I don't know when they are coming". A second person said, "They come at a variety of times, but they do always come". Some staff also expressed concerns about their schedules being unrealistic. They told us that the allocated travelling time between care visits was still insufficient and meant they could not possibly arrive on time to each call. A small number of staff told us that at times, care visits had not taken place due to lack of staff and were often later than planned. They all confirmed that they were not aware of any calls being missed, but confirmed that calls could at times be later than planned, but that people were generally understanding of this.

The registered manager told us this was largely due to commissioning arrangements and capacity planning which could have assessed the person as not having 'time specific needs' unlike others who would have to be prioritised. However, wherever possible, they did try and schedule people's calls to be at a regular time and undertaken by regular care workers. Records showed that the service was achieving some success with this, with 75% of calls being allocated to a consistent care worker. Weekly conference calls were been held with the other local branch managers to discuss and share ideas about staff recruitment and retention and analyse the reasons staff were leaving.

Staff told us there was an effective on call system in place to provide guidance and advice outside office hours. One staff member said, "The out of hours system is always there and there is always someone to answer. I am quite confident they would support, even [the registered manager] has come out to assist". The

electronic care management system used by the service sent alerts to the 'on-call' phone if calls were missed or not attended to within thirty minutes of the planned time. This allowed the on-call worker to investigate what might have happened or make alternative arrangements for the care to be provided.

The organisation had a business continuity plan which set out the arrangements that would be put in place if, for example, there was a loss of the office base or of the computer system. Arrangements were also in place to manage the impact of adverse weather or staff sickness on service delivery. This helped to ensure that, along with relevant support from the local authority, people continued to receive a service and had their needs met.

A record had been maintained of incidents and accidents. The recent records viewed were suitably detailed and showed that staff had responded appropriately to the incident. The registered manager continued to maintain an accidents and incidents log to assist in identifying any themes of trends that might need further remedial actions such as additional training for example. A new monthly conference call was being introduced for managers across the organisation to look at and share learning from incidents and accidents. This helped to ensure that lessons would be learnt and improvements made when things went wrong.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect.
Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the registered manager. They were also aware of other organisations with which they could share concerns about poor practice or abuse.

Staff were provided with range of equipment to help ensure good infection control such as gloves and aprons. During our visits to people in their own homes, we observed that staff were using personal protective equipment and following good infection control practices. The provider produced an annual infection control statement which showed that there had been no outbreaks of an infectious disease at the service in the last 12 months.

Good

Is the service effective?

Our findings

People told us they received effective care. One person said, "I like things done properly, I've never had to tell the carers to do something again as they do it right the first time". Another person said, "I am very satisfied with the care" and a third person said, "I have no complaints whatsoever". A fourth person told us that the carers stayed for as long as they should, "Sometimes a little over". They said they were "Never rushed". The service had received a high number of compliments about the care provided. Comments included, 'Very thorough and polite during initial assessment' and 'Outstanding dedication and support during my call today'. A care worker had been praised for 'Making [the person] laugh and being able to turn the situation around positively'.

New staff had a three-day induction during which they underwent a range of training which was mapped to the standards of the Care Certificate and included skills such as moving and handling, end of life care, safeguarding people, health and safety, infection control, first aid, the Mental Capacity Act 2005, dementia care and medicines management. The Care Certificate was introduced in April 2015 and sets out explicitly the learning outcomes, competences and standards of care that care workers are expected to demonstrate. Following the induction, new care workers were provided with an opportunity to shadow more experienced staff and underwent competency assessments in relation to moving and handling, administering medicines and practical care tasks. We did note that in two of the eight staff files viewed, there was no evidence that their overall competency to perform their role had been confirmed as part of a probationary review.

The training undertaken as part of the induction was refreshed on an annual basis as were the competency assessments. Whilst there was no overall training matrix available for us to view, the staff files viewed indicated training was generally up to date. Most people told us that the staff supporting them were well trained. For example, one person said, "Yes, they are well trained, they explain what they are doing". Another person said, "Yes, the carers are well trained…. we have had people round to watch the carers work to make sure they are doing a good job". Staff were also positive about the training provided. For example, one staff member said, "If I ask for something [training] I can get it. They encouraged me to take on some distance learning which I did, [the registered manager] likes us to be qualified with dementia and end of life care". Some staff had completed training to become Dementia Friends. The Dementia Friends Organisation describe a Dementia Friend as being someone who 'learns a little bit more about what it's like to live with dementia and then turns that understanding into action. The registered manager told us that since completing the training, staff were more confident ringing up the office and reporting that they had noticed a change in the way a person living with dementia was coping. This enabled them to make timely referrals to adult services, for example. Some staff had also taken on lead roles in specific areas. For example, we spoke with the 'I care' champion. They told us, "The way I discuss my work and my passion, people find it infectious so I speak with them on induction".

Where concerns had been raised about the competency of staff, the registered manager would undertake informal coaching sessions to discuss the concerns with staff to develop their skills and competency. There was also evidence that where required staff undertook 'Healthcare procedures' training which included information about caring for people who had stomas or catheters for example. Staff were also encouraged

to undertake nationally recognised qualifications in health and social care. As highlighted in the 'Safe' domain, we did identify some concerns about the confidence of some staff with some first aid interventions. We have asked the registered manager to review this with the staff concerned.

It was the provider's policy to provide staff with a minimum of four supervisions a year with at least one of these being a face to face meeting. The other three could be a competency assessment, a team meeting or an appraisal. We reviewed eight staff files and these reflected that most staff had received supervision in line with this policy. The staff we spoke with felt well supported and felt able to seek advice or support at any time from the registered manager or senior team. Supervision is an important tool to help managers and providers be confident that staff understand their role and responsibilities and perform these effectively.

Staff sought people's consent before providing care and told us how they encouraged people to make as many choices as they could about their care. For example, one care worker said, "I ask people what cereal they would like and offer a choice of sandwich, they always pick their own…. if they are a new person, we read the care plan but always as the person what they need too". Another staff member said, "I will show [person]…. I give them a choice of clothing, give them a choice to show their individuality".

There was evidence that people had been involved in discussions about care planning and most people had signed their care plans agreeing to the care being provided. 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. The registered manager told us that none of the people using the service currently lacked capacity to consent to the care and support being provided and therefore no mental capacity assessments had been required, but these would be used if there was doubt about the person's ability to consent to their care.

A number of people using the service required support with their nutritional needs. The level of support needed varied and might include heating a frozen or pre-prepared meal or helping a person to eat and drink. We observed a member of staff helping a person to take a drink. They provided this support in a person centred and unhurried manner. They told us, "It can take ten to fifteen minutes to help [person] with a drink, their swallow can change, we gently massage down the side of their throat as we have been shown, we would never leave her alone with a drink". Staff could describe to us the importance of protecting people from the risk of poor nutrition or hydration. Where people were known to be at risk of not eating well, food charts were put in place so that this could be monitored and concerns shared with relevant professionals.

There was evidence that staff liaised with health and social care professionals involved in people's care if their health or support needs changed. Care workers told us that if a person was unwell they would call office staff who would contact the GP and pass on their concerns to the person's family. One relative told us how staff had noticed their family member was unwell. They told us staff had "Called for the ambulance, reported it to the office and stayed until the paramedics arrived and then helped the paramedics, they were very calm and reassuring". Each person had a 'grab sheet' in their care plans which contained important information and could be shared with the emergency services should a person need to be transferred to hospital.

Good

Is the service caring?

Our findings

People and their relatives told us their care workers were kind and caring and that they had developed positive relationships with their regular care workers. One person told us, "They [the care workers] are kind all the time". A second person said, "I have four different carers who are most caring for me". A relative told us the care workers were "Special".

People were made to feel like they were valued. The service arranged to send cards to people on their birthday and during difficult times. For example, after an extended stay in hospital. This was confirmed by one person who told us they had been with the service so long that "The other day they [the service] sent me a bunch of flowers".

People had been involved in planning their care and were, wherever possible, given the opportunity to say how and when they would like their care to be provided. For example, one person told us how staff had visited her whilst she was in hospital to assess her needs and had "Sorted everything out for her". Another person told us that initially they had received four care visits a day but that this had become too much for them. They told us that they had spoken with Agincare and it was agreed that they would drop down to one care call a day which they felt was plenty and was working well.

The people we visited had service user guides in their care plan folders which provided details about how their care and support would be delivered and how people could expect their rights and individuality to be respected. People were assured of the right to expect person-centred care including retaining choice and control and having their confidential information protected. Whilst we only spent a short period of time observing staff, this and the overall feedback we received from people, indicated that they did receive care that was keeping with these values and contributed to their quality of life.

Care staff had a good understanding of how to ensure that people were respected and their dignity maintained. Care workers said they were mindful to ensure that when supporting people with personal care, bathroom doors and curtains were kept closed. The majority of feedback from people and their relatives was that staff treated people with dignity and respect. One person said, "They [care staff] treat his home with respect and are honest people". This same sentiment was repeated by a number of people we spoke with.

Care workers understood the importance of encouraging people to remain independent. One care worker told us, "I encourage them to do things for themselves. I don't do it for them if they can do it themselves, I encourage them to brush their hair and put mirror in front of their face. Rather than read an article from newspaper, I'll get their glasses, and listen to them". People confirmed that their care workers helped and encouraged them to be as independent as possible. One person said, "They try and encourage me to be as independent as I can be".

Good

Is the service responsive?

Our findings

People told us that staff knew them well and that they received person centred care that was responsive to their needs. One person told us, "You can't better them [the care workers] …they will do whatever I want". A second person told us, "We always have a little chat, they are like friends".

The care plans viewed contained information about people's preferences, likes and dislikes and their life histories. For example, we saw that one person loved dogs, liked to read and was working on their family tree. Information was available as to how people liked their tea and how they communicated. Staff talked to us about valuing getting to know the people they supported. For example, one care worker said, "I like getting to know the whole of the person and about their lives" and another said, "Every patient is different and has interests and we are briefed accordingly".

There was some evidence that where people had more complex needs, the allocation of staff was planned to try and provide the greatest consistency possible so that people and staff could build positive relationships. For example, one care worker told us, "I have six people who I go to religiously. One man, he can be mistrusting and needs one carer to build trust". We observed evidence of the positive relationships that staff had developed with people. For example, we observed care workers readily chatting to one person about their respective birthdays and joking about having a party together. The care workers knew the person's grandchildren's name and used this to try and encourage the person to communicate. Whilst the primary purpose of the visit was to provide personal care and nutritional support, it was clear that the person also enjoyed seeing her care workers and valued the relationship. A relative told us, "Yeah they [care workers] know her [family member] well, they do the job right, they go by her facial expressions, we have a chat, they are nice people". This person's care worker told us, "We know when she is happy or sad by the grip of her hand, on really good days we get a yes or a shut up!" The person's relative agreed that their family member recognised the staff members voice because of the consistency of care they received. At the end of the visit, the care worker knew to replace the relatives chair next to the person's bed, so that they could sit alongside the person, holding their hand. We received similar positive feedback about the care provided from the third person we visited.

There were systems in place to seek people's views and opinions about the service provided. Although people were mostly very happy with the care provided, some of the people we spoke with by phone felt more could still be done to keep them informed about which care worker was coming and to ensure that new care workers were introduced to them before they started providing their care. The provider's own telephone surveys showed that people were not consistently getting a visit schedule. An action plan had been developed in response to the feedback and drive improvements in this area. Annual quality assurance surveys were also undertaken. The 2018 survey had yet to take place but we were able to see the results from the 2017 which were largely positive. For example, 100% of those that responded said they were happy with the number of care workers they saw and were treated with politeness and respect. 100% of people also said they felt safe with their care workers.

The service had a complaints policy and information about how to raise concerns or complaints was

included in the service user guide which people had in their homes. We reviewed the complaints received. These had been responded to appropriately an in line with the providers policies. People told us that they felt their concerns or views were listened to. Complaints were audited monthly to identify whether there were any themes or trends that might require further action and these were also reviewed again by the provider. This helped to ensure that the provider had oversight of any emerging risks within the service.

The registered manager was aware of the Accessible Information Standard and a policy was in place to support this. They told us that should people have specific communication needs these would be met. For example, the service user guide could be provided in an easy read format.

Requires Improvement

Is the service well-led?

Our findings

People felt the service was well organised and well led. One person said, "Things are dealt with". Another person said, "It is very well led and the office is easy to contact, I changed my hours the carers come and it was sorted quickly". They told us, "I don't want anyone else".

There were systems in place to monitor the quality and safety of the service provided, however these were not always effective. For example, audits of staff files had not identified the concerns we found in relation to the robustness of staff recruitment checks. A medicines audit completed in August 2018, had not identified that follow up was needed to check whether gaps in people's medicines administration records (MARs) were an administration error or a recording error. This is important as if medicines administration errors have occurred, this could impact upon people's health and wellbeing. Care plan audits were undertaken monthly, but had not addressed the concerns we found in people's care records which are described below.

The provider undertook quality monitoring visits to the service with the last one being in July 2018. These audits were comprehensive and reviewed a number of areas including complaints, recruitment and training and performance. Overall the service was noted to be performing well in these audits, however, we noted that a number of required actions from an audit completed in April 2018, were also noted on the Audit in July 2018. For example, both audits had noted that some staff files lacked evidence of probationary meetings taking place. Deadlines for this to be completed had been missed. During our inspection, we also found staff files missing evidence of probationary meetings.

Records relating to people's care and support were not always accurate and up to date. For example, some people's care records lacked key information and some did not reflect the support being provided. As noted elsewhere in this report, one person's eating and drinking plan did not accurately reflect known risks regarding their nutritional needs. The plan did not refer to the fact they had an artificial feeding regime in place. The person's mobility and personal care plans were blank. An occupational therapy assessment from November 2017 was available in the care plan folder but the information within this had not been transferred to the mobility care plan. Staff administered this person's medicines via their PEG (a small tube which is inserted directly into a person's stomach so that they can be fed). The guidance regarding how to do this needed to be more detailed. A second person's eating and drinking plan stated that the person did not need assistance with eating and drinking, but we observed that staff were providing support with this. A third person lived with a stoma. The care plan stated that staff may have to assist with this, but there was not further detail regarding this. We noted falls and moving and handling risk assessments that were not signed and dated. Care plans seen did not include end of life wishes or preferences. Most of the care plans viewed lacked information about people's religious, spiritual or cultural needs. Staff told us that occasionally they were adding thickener to one person's drink. This is a prescribed product and helps the person swallow drinks more safely. The care plan did not include guidance regarding this. The registered manager told us this had recently been introduced and a care plan review had been booked for the following week.

During this inspection we found one repeated breach and one new breach of the regulations. This indicates

that the systems in place to monitor the quality and safety of the service provided had not been effective at identifying and responding to areas where the safety and quality of the service was compromised or to ensure compliance with the Regulations. People did not always have an accurate and up to date record of their care and support needs.

This is a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Good governance.

Staff were positive about the registered manager and felt well supported. They told us she was approachable and accessible should advice or assistance be needed. One staff member said, "[The registered manager] is definitely one of the better managers I've experienced". Another staff member said, "They [The registered manager] are very supportive to staff, you can always come to her with anything". A third staff member said, "I've had lots of managers who are awful, they can be all about the dollar, she [The registered manager] is good, you've only got to ring up, if I come in and need something done, its dealt with it immediately and she gets back to me to confirm this".

Staff felt that their feedback was valued. Team meetings were held and were used to discuss a range of issues affecting the people being supported and whether referrals might be needed to other health and social care professionals. Staff were asked for their suggestions to improve communication and encouraged to take up opportunities of undertaking additional qualifications to aid learning and career development. One staff member said, "Staff meetings are well attended, we can make suggestions".

Some staff continued to tell us that communication between care workers and the office could improve. We were told that sometimes additional calls were added to their rotas without them being told that this was the case. We were aware that the office team was currently missing some key staff which we understand will have increased the challenges of effective communication at times. We did see that some new measures had been implemented since out last inspection that should help to drive continued improvement with communication. For example, daily branch meetings were taking place. These reviewed a number of areas such as an update as to how the weekend had been and any staffing issues that might impact on care visits being covered. We did note though that these meetings were not always taking place.

It was clear that the registered manager had fostered a person-centred culture within the service and morale amongst staff was generally good. All the staff we spoke with, talked of enjoying their job and of the benefits they received from caring for people. For example, one care worker told us, "We care for poorly people who are forgetful, even on a day when things are not great, one diamond moment and you have made a difference and you feel it is special and worthwhile". The registered manager was proud of her staff team and there were formal systems in place to reward the team for doing their job well. For example, there was a 'care worker of the month' award. Taking into account feedback from people, staff voted for one of their colleagues who had gone the extra mile. The reward was a £25 voucher.

The registered manager and staff were actively working to maintain links with the local community. Every other month, the branch held a coffee morning for people using the service, but also for people living locally who might be socially isolated. The coffee mornings were well attended and some service users baked cakes to contribute to these. There was also evidence that the registered manager was working to build relationships with other local organisations and charities to develop these activities further.

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider had not ensured that all of the required checks were completed before new staff members started work. This is a continuing breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Fit and proper persons employed.

The enforcement action we took:

We served a warning notice on the provider and told them to make improvements.