Pulse Healthcare Limited

Pulse - Norfolk

Inspection report

Aspiration House
Unit K, Iceni Court
Norwich
Norfolk
NR6 6BB

Tel: 01603403000
Website: www.pulsecommunityhealthcare.co.uk

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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?	**Requires Improvement**
Is the service well-led?	**Good**

Summary of findings

Overall summary

The inspection visit to the agency office took place on 7 June 2017 and was announced. Further evidence was gathered during the week commencing 12 June 2017.

Pulse - Norfolk provides a domiciliary care service to adults and children across Norfolk and Suffolk in their own homes. People using the service have complex health care needs. At the time of our inspection, there were 20 people using the service.

There was a registered manager in post, who took up her management role at the end of 2016, and completed registration with the Care Quality Commission (CQC) in April 2017. A registered manager is a person who has registered with 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.

At the last inspection of this service in June 2015, we found it was good in all areas. At this inspection, we identified some concerns that the service was not always as responsive or safe for people as it should be.

People expressed some frustration at the length of time it took to investigate and resolve any concerns that they raised. The provider's own timescales for resolving complaints, or agreeing an extended response period with complainants, were not adhered to.

This was a breach of Regulation 16 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 end of the full report.

Systems for monitoring the safety of medicines management and ensuring people received them as prescribed, had declined and did not robustly identify concerns so they could be followed up promptly. The provider's representative had already identified this and directed the reintroduction of more regular checks. However, staff did receive training and checks on their competency, if they needed to administer medicines for people.

People had experienced missed calls, where there were insufficient staff with the right skills to deliver the care they needed to ensure their safety. There were contingency plans in place but sometimes people were without the right support at the right time. The registered manager had improved this over recent months and was exploring options for further action.

The registered manager ensured staff were recruited in a way that contributed towards protecting people from the employment of those unsuitable to work in care. However, the provider's systems for were not always robust in supporting the process. Staff who were appointed, understood their obligations to report concerns and suspicions that people might be at risk of harm or abuse and were confident these would be acted upon. They knew how to blow the whistle on poor practice and how to raise concerns with the

provider.

Staff were trained to be able to deliver effective care. This included training to meet the complex needs of people they supported and their competence to deliver care was assessed. People felt their regular carers had a good understanding of their needs and preferences for how they wanted their care delivered. This included their preferred routines, their health and social care and support they needed with eating and drinking where appropriate.

People's needs were regularly reviewed with them and there were checks in place to ensure their records remained up to date, or to take action if there were shortfalls. This enabled the service to be responsive to people's needs. People also felt that their regular staff had built up good, caring relationships with them and treated them with respect.

Staff understood their legal obligations to seek consent to deliver care and ensuring they acted in people's best interests where they were concerns about their capacity to make an informed choice.

Although relatively newly in post and only recently registered with CQC, the registered manager had a grasp of the risks and challenges within the service and had begun to make improvements. Staff could see what these were and felt that the service was becoming more proactive in identifying and dealing with issues that needed addressing.

The provider's quality assurance processes enabled people to express their views both formally through regular questionnaires and as part of visits to individuals. Where appropriate, there were clear action plans for the registered manager to make improvements where audit processes showed these were needed.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Although improving, there were not always sufficient staff with the right skills to fulfil people's visits.

Systems for managing and auditing medicines were not always sufficiently robust in ensuring people received their medicines as the prescriber intended and to address shortfalls.

The manager had implemented recruitment processes in a way that contributed towards protecting people, but the provider's actions had not wholly contributed to this.

Risks to people safety and welfare were assessed and staff understood the importance of reporting any suspicions of harm or abuse.

Is the service effective?

Good

The service was effective.

Staff received specialist training to enable them to support people competently.

Staff understood the importance of seeking consent from people to deliver their care and of acting in people's best interests.

Where it was required as part of care packages, staff supported people to eat and drink enough to meet their needs.

If necessary, staff sought advice to ensure people's health and welfare was promoted.

Is the service caring?

Good

The service was caring.

People had built up warm and compassionate relationships with their regular staff members.

People, with support from relatives if necessary, were involved in

decisions and choices about how they wanted their care to be delivered.

People's privacy, dignity and independence was promoted.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's concerns and complaints were not always investigated and responded to in a timely way, or in line with the provider's own complaints management process.

People's care was assessed and planned in a way that took into account their individual needs and preferences and staff understood how to meet these.

Is the service well-led?

Good

The service was well-led.

People were encouraged to express their views about the quality and safety of the service they received.

The new registered manager understood their role and had taken responsibility for making improvements.

The provider's quality assurance processes were effective in identifying what improvements were necessary and supporting the manager to take action.

Pulse - Norfolk

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.

The inspection visit to the office took place on 7 June 2017. It was announced and was completed by one inspector with telephone calls and further evidence gathered during the week commencing 12 June 2017. The provider was given 48 hours' notice of our office visit, because the location provides a domiciliary care service. We needed to be sure that someone would be available in the office to assist with the inspection.

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. The registered manager completed this and returned it when they needed to. We reviewed the content of this. We also looked at all the information we held about the service. This included information about events happening within the service and which the provider or registered manager must tell us about by law.

During our inspection visit to the service, we spoke with the registered manager, the provider's clinical governance lead, a nurse and two case managers. We reviewed records associated with the care of three people, incident records, medicines records for a further three people and medicines audits. We also checked recruitment and training records for four staff. We looked at minutes of a staff meeting, the complaints record and a sample of records associated with the quality and safety of the service including clinical governance audits.

After our inspection visit, the registered manager sent us additional information about missed calls for the period from January 2017 to the date of our inspection. She did this promptly when we asked for it. During the week following our visit, we gathered views about the service from four people or their relatives and from three other members of staff. We contacted nine commissioners of services. We received brief feedback from one of them.

Requires Improvement

Is the service safe?

Our findings

At our last inspection of this service in June 2015, we found that people were supported safely. However, at this inspection, we found that the safety of the service had declined in some areas.

There were times when there were not always sufficient staff to promote people's safety in a consistent way. Three out of four people or their relatives, expressed some concern that there were not always enough staff to cover their care needs. Sometimes relatives had to step in to provide care and sometimes staff from other agencies provided support.

A relative told us, "I don't believe they have enough staff … They struggle to get cover for [family member]." Another relative said, "Sometimes it is difficult to fill gaps and there's a problem occasionally with staffing. We have to go to another agency."

One person told us they had experienced a missed call about a fortnight before we spoke with them. They said, "There is no back up." They told us that the Pulse main office in Manchester was responsible for providing 'on call' support outside office hours and at weekends. The person told us how sometimes main office staff were not able to secure additional cover or that staff could be very late if they could find a suitable staff member. They explained, "I don't think it is any good ringing Manchester. I did it once when Pulse rang to say the carer wasn't coming. They tried to ring around for an agency nurse but two hours later, they couldn't find anyone. They were very apologetic but there was no Plan B." They added, "I just wish they would get sorted with back up and on call arrangements."

We found that the provider's national survey of service quality showed that over a fifth of respondents did not express a view about their satisfaction with the 'out of hours' team. However, a fifth of people who did express a view, were not satisfied with the 'out of hours' arrangements. This was consistent with our findings.

The registered manager sent us information about calls missed between January 2017 and June 2017. This showed that nine of the 20 people using the service at the time of this inspection, had shifts that were not covered. For example, one person had five unfilled shifts during the early part of 2017, so their family member had delivered their care. However, we noted an improvement and they had experienced no more missed calls since April. One person had a missed night shift but the agency was not made aware of this until the following morning. Another person had four visits in January and February where only one staff member arrived to support them and not two, as they required for their safety. The registered manager told us they had discussed this with the person's relative and commissioners, and rearranged the timing of visits to ensure adequate staff cover.

The registered manager said they intended to recruit and train additional staff, after another care provider withdrew from a part of a care package. They considered this would mean staff were better able to cover calls without recourse to individual emergency contingency plans.

There were contingency plans in place for each person to ensure people's safety if their calls could not be covered. This included using a competent worker the person may not know, the involvement of competent family members and the use of nursing staff from other agencies. The last resort for people was a "place of safety," such as being admitted to a nursing home or hospital. We were aware that some people had anxieties about that, as it would mean leaving their homes. The registered manager confirmed that they shared contingency plans with commissioners for care. One commissioner responded to our request for information to confirm they were aware of the arrangements.

We found that the provider's staff application forms issued to applicants, for ten years of employment history and not the full history required by law. The provider's clinical governance lead checked this and told us that recruitment staff had printed an old application form. They told us they would address this to ensure consistency. However, we were aware that the same shortfall in employment histories was identified at inspections of two other locations operated by the provider of this service.

Although the application form did not prompt staff for full information, we noted that the registered manager had applied a proper recruitment process. She had obtained CVs from the staff appointed with full employment details to help ensure safe recruitment procedures. We saw that the registered manager took up references before staff were appointed. We also noted they had completed enhanced checks with the Disclosure and Barring Service (DBS) in a timely way. This helped to ensure that staff did not have criminal records that would make them suitable for their posts and that they were not barred from working in care services.

There were concerns that people may not consistently be receiving their medicines as the prescriber intended, because auditing and checking systems were not sufficiently robust. Systems did not identify omissions or errors consistently so they could be followed up and investigated promptly.

Most people, or their relatives spoken with, told us they did not need staff to support them with their medicines. One relative told us that they did not believe staff had made any mistakes with medicines. However, they said that they felt staff did not always prompt their family member sufficiently. They told us, "I went round at 11am one day and found their tablets still on the table from 9am. If staff explain what they are for and remind [person], my [family member] will take them. I don't think they did." They said if this did not happen the person would forget because of their memory problems, so the person may not receive their medicines in a timely way.

The provider's clinical governance lead supplied us with the findings of their most recent detailed check on information for five people's care packages, completed on 12 April 2017. This showed that there was no recent audit of those people's medicine administration records (MAR). This compromised the how promptly the management team could investigate and address any concerns about medicines management.

The lack of regular checks may have contributed to the failure to identify the omissions we found. For example, we reviewed one person's MAR for March 2017 where the electronic incident record showed one omitted signature for a medicine on 21 March 2017. We found further omissions of seven other signatures for the same person during that month, none of which was identified in incident records. For some of these, staff had recorded in daily notes that they gave the person their medicines with a drink. However, daily notes did not always show whether staff had supported the person with medicines administered by inhalation. This meant it was unclear from both the MAR chart and the daily records, whether the person had received the medicines they required.

The provider's action plan arising from their own check directed the reintroduction of regular audits

immediately. This meant that that the process for checking that staff administered medicines properly and safely would be more robust in future.

Staff spoken with confirmed that, if they needed to be involved in administering medicines, they had training to enable them to do so safely. They told us their competence to do this was checked if medicines management was a part of the care package they worked on. We saw that this was included in staff records. These showed that staff had to demonstrate they could administer medicines safely on three occasions before they assumed responsibility for doing this.

People told us that they felt staff supported them in a safe way. For example, one person with mobility difficulties said the care they had received had helped maintain their skin integrity. They told us, "I have no problem with bed sores, they help me with cream regularly and I've never had a bad problem."

Staff were able to describe risks to people they supported and how they managed these. They felt they had enough guidance about supporting people safely. We noted that people's care plans contained information about the risks to which they were exposed, with guidance for staff about managing them. These included risks associated with mobility, to skin integrity, from choking and related to specific health conditions.

Staff had training in first aid and resuscitation techniques for both adults and children. Staff confirmed that they had additional and specific training to deal with emergencies that might arise as the result of people's individual health conditions. A nurse told us how they assessed staff competency to manage such emergencies. A relative confirmed that this had happened. They said they might be over-anxious about the person's safety in an emergency, but the nurse had reassured them that staff were able to respond appropriately. The management team were introducing a "Safe to Start" process for new staff, to contribute to ensuring people's safety and staff competence in all the required areas of care.

There were systems in place to help protect people from the risk of harm or abuse. People spoken with felt that staff contributed to protecting them. They, or their relatives, told us that they had no concerns about the attitude of staff and the way they were treated. We noted that the registered manager had investigated one concern with advice from the provider's head office to ensure the issue was properly addressed.

We noted that our registration team advised the registered manager to undertake specific training in safeguarding for service providers and managers. The registered manager told us that they had not yet been able to do this, as the expenditure needed approval. They told us they would be completing it in the near future.

Staff confirmed they had training in safeguarding people. They told us about the kinds of things that would lead them to be concerned people were being abused or at risk of harm. They were confident in reporting their suspicions and that the management team would take action. They also described to us how the provider had a separate dedicated e-mail address that staff or clients could use to report concerns to a senior member of the provider's management team, anonymously if they wished. This confirmed what the registered manager had told us in their Provider Information Return sent to us before our inspection.

Good

Is the service effective?

Our findings

At our last inspection of this service in June 2015, we found that people received a service that was effective in meeting their needs. At this inspection, we found that outcomes for people remained good in this area.

People received support from staff who were trained to meet their needs effectively. People and their relatives were aware that staff did need time to get to understand their needs and develop confidence in meeting them. People told us that their regular staff members understood how to meet their needs and the care they required. One person told us, "I have three regulars [staff]. They are all very good and know what they are doing. I don't like them sending anyone who doesn't know me. They do competence checks and training so staff do all the things they need to." They described their regular staff as, "…very competent."

One relative told us that they had been concerned about staff confidence to respond to health related emergencies, but staff were provided with additional training. They told us, "I'm happier that they know what to do." Another relative explained that most regular staff understood the support their family member needed and, "Most of them will also read up in the care plan so they know." They told us how the agency had sent one carer for their family member "…who hadn't visited before and didn't read up properly. They didn't have a clue really but it was sorted out. I've had no problems since."

Records confirmed that there was a range of suitable training accessible to staff, in addition to their induction training. The management team told us that the electronic system did not allow staff to be rostered to specific complex care packages until their specialist training was complete. We reviewed the arrangements for regular staff allocated to one person's care package in detail. We saw that they had completed training that matched the person's needs and any emergency intervention they needed to make.

Staff spoken with told us about their training. They explained that they had additional training that was specific to the complex needs of clients they were supporting. One told us they felt that the training they had at this agency was the best they had during their time working in care services. This included training in managing respiratory problems, use of suction equipment, catheter care and emergency replacement of tracheostomy tubes. Staff all described how they had the opportunity to complete 'shadow' shifts to learn about people's needs.

Case managers offered supervision to members of their staff teams and received supervision themselves from the registered manager. They said that sometimes this was informal but there were very regular meetings with the registered manager for them to discuss issues and seek support with managing them. A member of nursing staff told us how they accessed additional support and supervision to enable them to retain their registrations and enhance their clinical skills.

Staff said that they were able to get support and office staff would ring them back if they were not available straight away. One told us how they had needed to contact the main office in Manchester when they needed support and advice after office hours. They said that they received this and were reassured because of the advice and guidance they were given. One staff member described how they felt well supported when a

member of the nursing team gave them feedback on their work. They said this was constructive and encouraging so that they could improve when they needed to.

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

Staff were able to tell us how they supported people who may not be able to make informed decisions about their care. They confirmed that their induction training covered this area. They were aware of their responsibilities in seeking people's consent before providing any care or support. One staff member explained in detail how they would present information, try to help the person retain it and discuss it. They recognised the person's capacity could fluctuate and sometimes they would need to offer more support than at others. They also recognised their obligation to act in the person's best interests to promote their safety and welfare.

We noted that there was information running through people's care records about how they made decisions and what information staff needed to provide. We saw that people had been asked for their consent as part of their care planning review. We discussed with the registered manager, the use of the term "consent to care." This was included within care plans and some relatives had signed where people were unable to do so. The registered manager confirmed that the record was about people being involved in discussions and agreeing with their care plan. They told us it did not represent the relatives giving legal consent to the delivery of care. The registered manager explained to us how one person's next of kin had been involved in giving formal consent, due to the person's age. They recognised the role of the Court of Protection in ensuring that the next of kin was properly authorised to make decisions about health and welfare as the person moved to adulthood.

People told us that, where it was part of their plan of care, staff prepared their food and drinks. One person told us, "They always make sure I have a drink to hand." A relative confirmed that staff prepared meals for their family member and ensured they had something to eat and drink. Staff were aware of people for whom there was a risk of choking and about how they needed to prepare meals and drinks for the person to avoid this risk. Where people were unable to take food and drink orally and had tubes in place for delivering this, staff had training to ensure that could receive their nutrition and fluids properly.

Staff told us that they were not normally responsible for assisting people to seek advice about aspects of their health and welfare not covered within their care plans. However, they told us they would seek advice from emergency services if there was an urgent concern and help people to refer to health professionals if they needed support. They said they could also seek advice about non-urgent issues from the agency's nursing staff or through on-call arrangements, and one person was receiving support and treatment from the district nurse team. One of the agency nurses told us that staff did contact them if they noticed a change in someone's health. They told us that they would follow up with the person, their GP if necessary and seek referrals such as to the dietician, occupational therapist or physiotherapist if appropriate.

Good

Is the service caring?

Our findings

At our last inspection of this service in June 2015, we found that people experienced a caring service. At this inspection, we found that outcomes for people continued as good in this area.

People felt that their regular carers had built up good relationships with them. They were aware that new staff sometimes had to be introduced to their care packages and it could take a while to build up relationships with them. One person told us, "My regulars are very professional. Care wise I'm very happy with them." They went on to explain that a new staff member had been introduced to them and that they felt, once the staff member started working regularly with them, they would get on well. People and their relatives said that staff checked whether anything else needed doing before they finished their visits.

People were able to express their views about the way they wanted their care delivered. For example, one person told us that they felt the agency listened to them if they did not get on well with a staff member for some reason. They said, "I have got a say. They do respond and change them around if they can."

A relative described the process of assessing their family member's needs before they started using the agency on a full time basis. They told us, "They [staff] listen to our views [about what we need] and try to make sure that happens." They felt that the nurse they were dealing with worked in partnership with them to ensure staff could deliver care as the person wanted.

The provider's questionnaires for people using Pulse – Norfolk, showed three out of five people felt that staff assisted them to meet their personal goals and aspirations. The provider's analysis shared with people, reminded them they could contact their case manager if they felt there were areas where staff could offer more support or assistance.

Staff treated people with respect. A person told us, "None of them [staff] are rude. They are polite and we do have a bit of banter. Sometimes I get grumpy. I don't mean to and I can take it out on them, but we're friends by the end of the shift." They went on to describe their longer standing staff members saying, "They're like a friend as well." A relative told us about the care team supporting their family member. They said, "We have quite a few staff. I am comfortable with them. They have a good attitude, are pleasant and get on with [family member]." They said they would give the agency, "…eight or nine out of ten for care."

People's privacy and dignity was respected in the way that staff delivered care. A relative told us, "I think they do respect [family member's] dignity. They always do personal care in [family member's] room and in private." People's responses to questionnaires, analysed in April 2017, showed that all five people responding felt that staff respected their privacy and dignity.

Staff spoken with about people's dignity, were able to describe in detail how they promoted this and people's privacy when they were delivering their care. One told us how this would involve helping cover the person's body while they washed another part and ensuring they closed the bathroom door. They told us that they would always explain what they were doing and ask for the person's permission.

People told us that they felt staff generally encouraged them to do what they could for themselves, promoting their independence as far as possible. For example, one person told us, "I just need someone there to make sure I am safe, then I can do [aspect of care] for myself." One relative felt a member of staff did not always encourage their family member as much as they could. However, they told us that regular staff were good at recognising what their family member could do and made sure they involved the person and promoted their independence as far as possible.

A staff member was able to explain how they supported a person with their independence, this included with their personal hygiene and completing as much of their washing and dressing as they could. They recognised that they needed to be aware how the person was feeling and their general health. They knew this would affect the level of support they needed with their mobility and sometimes they would need more assistance from staff.

Requires Improvement

Is the service responsive?

Our findings

At our last inspection of this service in June 2015, we found that people received a service that was responsive to their needs. At this inspection, we found that there were regular reviews and updates to people's care. However, people did not always receive a timely investigation and resolution of their concerns and complaints.

People or their relatives told us that they would contact the agency office if they had concerns about their care. They were confident that case managers would listen to their concerns. However, they also told us that they did not always receive a call back or response, as quickly as they would like. For example, one person told us, "If I have a complaint, they do follow it up, but not that quickly." They went on to tell us that it took a long while to resolve issues and that, on occasion, office staff did not always return calls.

The provider's questionnaire for people using this branch of the agency received five responses. These showed that only one person agreed that they were happy with how their complaint was resolved. Two were not. Concerns about the way complaints were handled were also reflected in the provider's national survey. The registered manager explained that there had been changes in arrangements so that there would always be one of the three case managers available during office hours. They felt that this would improve the initial response people received when they first contacted the office to raise a concern.

The registered manager told us in their provider information return (PIR), that incidents and complaints were handled and monitored by a central team. This enabled them to monitor and identify any trends and to follow a consistent process. The information showed four complaints were handled under their formal complaints procedure during the 12 months leading up to submitting the PIR in April 2017. Three of these were resolved within 28 days.

During our inspection visit to the office, we found that the electronic complaints record showed five complaints about the service since January 2017. Two of these were overdue for resolution, did not show that the complainant was told about the reason for any delay and when they could expect the investigation to be concluded. One of them was outstanding from 19 April 2017, seven weeks before our inspection took place, and without an outcome.

This was contrary to the provider's complaints management process which we checked. This stated that people would receive an acknowledgement of their concern within three days and an investigation and response within 28 days. It showed that, "If the investigation is complex and requires more time, a timescale will be agreed and communicated with the complainant." The policy further detailed that, "A final outcome letter detailing the investigation and all actions taken must be sent to the complainant within 28 working days (if however this is unachievable, a mutually agreeable date may be decided upon between parties) of the receipt of the complaint." This had not happened and supported people's views that, on occasion complaints were not promptly investigated and resolved.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations

2014.

Care planning processes contributed to people receiving care focused on their individual needs. Where there were omissions or shortfalls in the information care plans contained or in the assessments completed, the provider's auditing processes identified this. There were clear timescales for action staff needed to take to ensure records relating to people's care were fully complete and kept up to date.

People or relatives spoken with told us that they were involved in assessments and reviews of their care. One relative told us that an agency nurse had visited them to complete assessments and to help plan care for their family member, before the care package started full time. They said, "We have written the care plans together to make sure they're right. They have taken on board what we have said." They went on to describe the agency as being, "…responsive to what we want and what we are looking for." Another relative told us, "Most of the care staff will always read up in the file to see what has happened and whether anything has changed. It's all in there."

One relative described how a staff member had not always respected their family member's preferences in the past, for when they were assisted to go to bed and to get up in the morning. However, they felt things had improved and that the person's routine was now more suited to their preferences.

Staff were able to describe clearly the needs and preferences of people they supported. Where people, or relatives, described support needs to us, the information was consistent with what we had seen in people's care plans and records.

The provider's questionnaire results for this branch of the agency showed that only one of the five people responding knew how they could make changes to their care package. Because of the analysis of this and of questionnaire results across the country, the provider had shared information with people about how they could make changes. This reminded people they could contact their local office and that staff would help to implement the changes.

Support with people's social and recreational needs was a part of some of the care packages staff delivered. People told us that they were satisfied with the way staff assisted them with these if it was a part of their care. Their plans of care reflected their preferred activities and interests if they needed staff support in this area.

Good

Is the service well-led?

Our findings

At our last inspection in June 2015, we found that the service was well-led. At this inspection, we found that leadership and management remained good. A new registered manager had assumed responsibility for running the service and completed their registration with the Care Quality Commission in April 2017, not long before this inspection. They had a good understanding of their role, the challenges facing the service and the improvements they needed to make. The provider's quality assurance systems contributed to this and had identified shortfalls both locally within this branch of the agency, and nationally.

Despite the delay in the provider's central team taking action to deal with formal complaints, people who had made any contact with the incoming manager found her approachable. For example, one person told us, "I get on very well with the manager and she does listen." A relative told us, "I have spoken to the manager. I can talk to her and she will try to resolve things." Some people had not yet had much contact with the registered manager but could identify other members of the management team who they felt were competent in their roles.

People using the service, or their representatives, had opportunities to express their views about the quality and safety of the service they received. We noted that the service tailored the frequency of reviews of care to the level of need of people using the service. To ensure clinical care remained safe and appropriate, people with the most complex needs and highest risks to their safety, received reviews most frequently. Review records for both clinical and social needs, included opportunities for people to discuss their care, what they thought about the staff supporting them, and to express any views about what they wanted to see changed.

There was also a process for seeking people's views in questionnaires, last issued and analysed in April 2017. The provider analysed the results nationally across their services. This meant that the registered manager could see how this service was performing against the provider's other services across the country. The provider's clinical governance lead showed us how they carried out specific checks with a sample of people using this service. Their audit reports included comments from people about their care and identified any improvements that were needed.

Staff told us that there were meetings for them to be able to express their views and share information. However, they could not always attend them if they had other work or training commitments. A member of the management team told us how they were looking at options to hold some meetings nearer to staff places of work, given the agency supported people across Norfolk and Suffolk. They felt this would help improve opportunities for staff to attend. We also found that the provider's clinical governance lead asked staff on duty for their views as a part of their audit process. The registered manager described how they were introducing a reward scheme for staff who had performed especially well to ensure they felt valued in their roles.

The registered manager recognised that staffing rosters had been a concern for people, who did not always know which staff were coming. They had introduced a 'rolling roster' for staff and a care coordinator allocated to planning rosters a month in advance. They were aware that the arrangements for covering the

roster and filling shifts were of concern to people using the agency and seeking to improve this. We noted that the level of missed calls had decreased since early in 2017. The registered manager was recruiting and training additional staff to help address this risk.

Staff we spoke with were enthusiastic about their work. They told us they felt that morale was good. They felt that some aspects of teamwork, including elements of staff grumbling about others, had improved. One of them described the new manager as, "…doing a good job and trying to be fair." Another described how they felt that the new management team were clearer with them about expectations and there were more structured guidelines about their work. All of them said that they would be very happy for a relative of theirs to receive support from the agency.

A staff member identified to us how communication had occasionally failed between people using the service and the office, with messages not always getting through. Office staff recognised that there was a new and young management team, needing time to consolidate, but said they felt communication was improving. They said this helped to ensure they had access to relevant information to answer queries if people contacted the office. They felt the new registered manager was improving the way that the agency branch was running.

The registered manager had recognised the need to improve the way the office was operating. There was an additional case manager to ensure there was better monitoring of care packages. One of the case managers told us how they felt that this had the way that staff could receive supervision and monitoring of care packages was more manageable

Case managers and a nurse identified improved support from the provider's representatives and said they felt they had access to more sources of advice or support. They told us that they felt the service was becoming more proactive in identifying and responding to challenges and risks. They said they felt the registered manager took their views and opinions into account. One of the office staff told us how they felt they received constructive feedback about their performance and there was always someone to go to with their questions. They explained this made them more confident they were not going to make bad decisions about people's care or in response to concerns.

The provider's systems supported the registered manager in driving improvements in the quality of the service. The provider's clinical governance lead checked the content of records in place at their visits to people. This helped to ensure that the service maintained up to date and accurate records and to identify what needed to happen if they were not. They also monitored evidence that staff had the specialist training they needed to deliver care to individuals. After these visits, they compiled an action plan for improvement. This showed who was responsible for taking action and when they expected it to be complete. The clinical governance lead told us how they monitored improvements with the registered manager to ensure they were made.

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 Treatment of disease, disorder or injury	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints Systems for investigating and responding to complaints were not operating effectively. Complaints were not all investigated and responded to in a timely way and complainants were not always kept informed of the progress of the complaint. Regulation 16(1) and (2)