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

Summary of findings

Overall summary

This inspection took place on the 16 and 19 June 2017 and was announced. The provider was given 48 hours' notice because the location is a domiciliary care service and so we needed to be sure that key staff would be available at the office.

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. There were 57 people using the service at the time of this inspection.

The service did not have 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. A new manager had been appointed in February 2017 and was currently applying to the CQC to become registered. Prior to this, the service had an extended period during which there had been a number of changes in management which people and staff felt had impacted upon the consistency of leadership and the support provided.

Recruitment practices continued to be unsafe. We could not be assured that all of the required checks had been completed before new staff members started work.

Improvements were needed to ensure that medicines were managed appropriately.

More needed to be done to improve the consistency and reliability of the service and to prevent the risk of missed or late calls.

Audits were not being fully effective at ensuring the quality and safety of the service.

Improvements had been made which helped to ensure that people had a care plan which provided adequate information about their needs and supported staff to deliver responsive care.

The new manager had taken action to ensure that staff had all of the training relevant to their role and to ensure that staff felt supported and understood their role and responsibilities.

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

Staff acted in accordance with the key principles of the Mental Capacity Act 2005 (MCA) and people's choices were respected.

People were supported with their health and nutritional needs.

People were treated with kindness. They felt involved in how their care was planned and provided and felt that their privacy and dignity was respected.

The manager was strengthening the systems in place to ensure that complaints were effectively managed and used to drive improvements.

Staff told us the manager was effective, approachable and had an understanding of the challenges faced by the service. They expressed a growing confidence that the new manager would continue to make improvements.

We found one breach of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. You can see the action we have asked the provider to take in the main 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?

Requires Improvement

The service continued to be rated as requires improvement.

Recruitment practices were not always safe. We could not be assured that all of the required checks had been completed before new staff members started work.

Improvements were needed to ensure that medicines were managed appropriately. We could not therefore be confident that people were always receiving their medicines as prescribed.

Improvements were underway to ensure that there were sufficient numbers of staff to prevent the risk of missed or late calls.

A record had been maintained of incidents and accidents that affected the health, safety and welfare of people using the service and these were 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. Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed.

Is the service effective?

Good

The service was now rated as good.

Staff acted in accordance with the key principles of the Mental Capacity Act 2005 (MCA). This is important as it helps to protect the rights of people who may not be able to make important decisions themselves.

Staff had received appropriate support, training, professional development and supervision to support them to carry out their role effectively.

People were supported with their health and nutritional needs.

Is the service caring?

Good

The service continued to be rated as good.

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

People were treated with respect and that the support they received helped to maintain their independence.

Is the service responsive?

Requires Improvement

The service continued to be rated as requires improvement.

More needed to be done to improve the consistency and reliability of the service.

Improvements had been made which ensured that each person had a care plan which provided adequate information about their needs and supported staff to deliver responsive care.

The manager was strengthening the systems in place to ensure that complaints were effectively managed and used to drive improvements.

Is the service well-led?

Requires Improvement

The service continued to be rated as requires improvement.

Despite improvements, the service still needed to be more organised to ensure that concerns or issues were dealt with effectively. Communication within the service was improving.

Audits were not being fully effective at ensuring the quality and safety of the service.

Staff told us the manager was effective, approachable and had an understanding of the challenges faced by the service. They expressed a growing confidence that the new manager would continue to make improvements.

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 16 and 19 June 2017. 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. We asked the provider to complete 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. As some people were unable to share their views about the service, we also spoke with seven relatives. During our visits to people in their homes, we spoke with two people and two relatives. We spoke with the manager and deputy manager, a care co-ordinator, a field care supervisor and six care workers. We reviewed the care records of six people and four staff and other records relating to the management of the service such as audits, incidents, policies and staff rotas.

Following the inspection we obtained feedback from a social care professional about their views of the care provided by the service.

The service was last inspected in April 2016. That inspection found that improvements were needed to

ensure that people's needs were being met in a responsive manner, that recruitment practices were safe and to ensure that staff had all of the training relevant to their role.

Requires Improvement

Is the service safe?

Our findings

Overall people told us they felt safe when being supported by the care workers. One person felt that some staff would benefit from being more knowledgeable in the use of aids and equipment. Another person told us that staff often did not wear their identity badges. They said, "I do have one reservation and that is the carers don't wear name badges so if new person arrives who I have not seen before there is little ID. It could be anyone".

Our last inspection in April 2016 had found that improvements were needed to ensure that appropriate recruitment checks took place before staff started working at the service. This inspection continued to find concerns about the safety of recruitment. People were placed at risk because full and thorough information was not obtained about staff before they were offered a job at the service. For example, one person did not have a complete set of references. Staff had not taken sufficiently robust action to follow this up with the person's previous employer. This person had been employed before the current manager was appointed and action has now been taken to obtain the required information.

Staff had completed an 'Adults First' check for another member of staff. An 'Adults First' check is a service that can be used to allow a provider to check whether a care worker has been barred from working with adults who require care and support. It serves as an interim check and means that the care worker can start work whilst awaiting a full disclosure and barring service (DBS) check. DBS guidance states that 'Adult First' checks should only be used in 'exceptional circumstances and when absolutely necessary'. The 'Adults First' check completed for one member of staff had recommended that the service await the full DBS before making a recruitment decision. This recommendation was not acted upon. A risk assessment had been put in place, but this was not sufficiently robust. For example, under 'avoid lone working' the risk assessment recorded 'not required'. Under weekly supervisions, the risk assessment said, 'not required'. The member of staff worked for a month before their full DBS was returned. The manager confirmed to us that she could not be confident that the worker had not completed care calls on their own during this period.

In one of the staff records viewed, we found that a full employment history had not been obtained. This information is important as it allows relevant background checks to be undertaken. This information has now been obtained. 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.

Improvements were needed to ensure that medicines were managed appropriately. During our home visits, we reviewed the medicines administration records (MARs) for three people and in two of these we found gaps where staff had not signed to confirm that the medicines had been administered. In the case of one person we visited, the MAR did not reflect the medicines staff were administering. A relative told us their family member had not received a new medicine for a period of three days despite this being recorded on their MAR and the office being informed of the change. We could not therefore be confident that people were always receiving their medicines as prescribed.

Staff managed other aspects of people's medicines well. Where required, people had a medicines management assessment which described the level of support they needed to manage their medicines safely. Staff were able to describe how they supported people with their medicines and the records they maintained in relation to this. Where people required '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. We did note that staff were not clear about whether they should leave medicines out for a person to take later. We have asked the manager to confirm the procedures for this with staff.

We received mixed feedback about whether they were always sufficient numbers of staff available to cover the number of care visits provided. Most people told us their scheduled visits were provided even if sometimes, this was later than planned. Where two staff were needed for a visit, all of the people we spoke with said two care workers were rostered and this was confirmed by the staff we spoke with. However, some people still felt more staff would improve the service they received. One person said, "They never seem to retain staff long term so many are not fully trained to meet my father's needs". A number of people told us they had on occasion had one of their calls missed. We spoke with the manager about this. They told us they were not aware of anyone experiencing missed calls. However, when we reviewed a selection of people records we noted that one person had experienced a missed call in the week prior to our inspection. An investigation showed this was due to scheduling issues and confusion over rotas. The manager told us that recruitment remained a priority and they were being supported in this by a recruitment manager with whom they having weekly meetings. This helped them to judge whether they could accept any new requests for care safely. They were confident that improvements to how care visits were co-ordinated and planned would ensure that the risk of missed calls was now minimised. They were also taking more robust action to ensure staff used the care monitoring system which provided alerts to office staff if a care visit was not logged as completed by care workers. Arrangements were now in place to monitor this live and if a care worker did not log into a call, office staff were ringing them immediately to find out why. Where staff persisted in failing to use the system, the manager told us further action would be taken. These processes will need to be embedded in practice and sustained in order to ensure that there are effective safeguards in place to avoid the risk of missed calls.

Staff told us they did not always have the information they needed to provide care safely. One staff member said, "If there is a new person, you very rarely have any information, no care plan or notes, they might not have capacity to tell you about their own needs". Two other care workers shared similar concerns.

Risk assessments were in place for moving and handling, falls and medicines management. For example, the medicines risk assessment tool considered how the person's mental state, their vision and their health might impact upon their ability to manage their medicines safely. Care plans also contained a general health and safety risk assessment which considered a range of environmental risks. The risk assessments viewed would benefit from having further information about how the identified risks were to be managed. This had been a concern at our last inspection.

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 wherever possible people continued to receive a service and had their needs met.

A record had been maintained of incidents and accidents that affected the health, safety and welfare of people using the service. The recent records viewed were detailed and showed that staff had responded appropriately to the incident. For example, staff had called emergency services to assess people who had

fallen and contacted their families and other agencies as necessary. Following a medicines error, medical advice had been sought and the manager had arranged for the staff member to refresh their training and have their competency to administer medicines reassessed. The manager maintained an accidents and incidents log to assist in identifying any themes of trends that might need further remedial action such as referrals to the falls team. This demonstrated that incidents were being effectively used as an opportunity for learning. The provider also had oversight of the incidents and accidents that occurred allowing them if necessary to take action to ensure people were safe.

New staff completed safeguarding training during their induction and were able to describe the nature and types of abuse they might encounter and the relevant reporting procedures which were detailed in the provider's policy. For example, one care worker told us, "If I see unexplained bruising, I note it, complete a body map and inform the office". Relevant contact numbers for the local authority safeguarding team were displayed within the service and the local multi-agency policy was also available. Incidents of concern had been escalated to the local authority for investigation where necessary, although feedback from a local social care professional indicated this did not always happen reliably. They told us, "Sometimes there is still a problem that we don't hear back from Agincare as soon as we need to when there are concerns and this is also reported to us by families from time to time". Staff were aware of the whistle-blowing procedures and were clear they could raise any concerns with the new 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, aprons, face masks and hand sanitizer. During our visits to people in their own homes, we observed that staff were using personal protective equipment and following good infection control practices.

Good

Is the service effective?

Our findings

The majority of people told us their usual care workers were competent and well trained. One person said, "I think they are quite good and meet my needs". Another person said, "The majority of carers seem to be quite competent in what they do". Our observations during the inspection indicated that staff cared for people in a competent manner. We observed staff undertaking moving and handling tasks appropriately and supporting people in a manner that demonstrated they had the knowledge and skills to undertake their role effectively. Some people felt that new or inexperienced care workers could be better equipped with the skills they needed before providing care. For example, one person said, "One couldn't manage to operate my bath aid". Another person said, "They could do with more training on how to put on support stockings with the right aid. I do show them and they are willing to learn, but it would be good if they knew before they came".

Our last inspection had found that staff did not have all the training relevant to their role. This was because, the provider was not able to demonstrate that the longer serving staff had received their annual refresher training in a number of key areas such as moving and handling and infection control despite the provider requiring these to be completed on an annual basis. This inspection found that improvements were being made.. Most staff had now completed safeguarding, infection control training and training in managing medicines. They had also had an annual assessment of their competence to administer medicines safely. Whilst the provider did not require staff to undertake practical moving and handling training refreshers, records showed that staff had undergone a moving and handling competency assessment and a theory based knowledge test of moving and handling principles. Our last inspection had found that staff had not undertaken additional training relating to the specific needs of people using the service. For example, training in the Mental Capacity Act (MCA) 2005 and caring for people living with dementia. Records now showed that this was an improving picture, although some newer staff were still to complete this training. In the interim, the manager was undertaking teaching sessions on the MCA 2005 with staff. Some staff had been signed up to complete distance learning courses in areas such as end of life care and the principles of care planning. A staff member told us, "We are always being offered training, I have just started my NVQ3".

It was the provider's policy to provide staff with three supervisions a year. Agincare's expectation was that at least one of these would be a face to face meeting. The other two could be a competency assessment or a team meeting. Records showed that most staff had so far in 2017 received both a competency assessment and face to face supervision. All of the staff we spoke with felt well supported and felt able to seek advice or support at any time from the manager or senior team. Not all staff had received an annual appraisal but we able to see that these were underway. Supervision and appraisals are important tools to help managers and providers be confident that staff understand their role and responsibilities and perform these effectively.

New staff undertook a two or three day induction programme, depending upon their existing experience, during which they completed some essential training which included moving and handling, safeguarding people, infection control and person centred care. The induction was mapped to the Care Certificate. 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, during which time they were able to meet people using the service. The manager told us that the length of shadowing required was based upon the person's previous experience and assessed skills and knowledge.

People told us that staff sought their consent before providing care. One person said, "Yes they always ask me if I am ready for the shower or other tasks or what I want done, it all runs smoothly". This was echoed by a second person who said, "They always ask me what I want done and how". Where people were unable to provide consent, staff worked in a manner that was in keeping with the principles of the Mental Capacity Act 2005. 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 saw examples where mental capacity assessments had been carried out by senior staff in line with the MCA 2005 which were decision specific. Where people were deemed to lack capacity, there was evidence that staff had liaised with family members, GP's and care managers to seek their views about and to ensure that the care plan being delivered was in the person's best interests.

A number of people using the service required support with meal preparation. Often this involved the care worker heating a frozen or pre-prepared meal brought by family or delivered by a meals service or making a light snack. People and their relatives told us that staff provided appropriate nutritional support. One relative said, "I do the shopping for mum including frozen meals, they ask mum what she would like by showing her pictures of what's in the boxes, they give her plenty to drink while they are there and leave her drinks and snacks by her armchair".
Staff told us they were informed about any special dietary requirements people might have and were able to 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 were raised with relevant professionals. We did note that food and fluid charts were not being consistently used. Sometimes, staff recorded on the chart, sometimes in the person's daily notes. On one of the charts viewed staff had simply recorded 'water'. It was not evident how much water the person had drunk. We have recommended that the manager review how fluid charts are being used to ensure these continue to be an effective monitoring tool.

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. For example, records showed that staff had noted that one person was 'not themselves'. They had called the out of hours doctors who had established that the person had a urine infection that required treatment. We also saw evidence that staff had contacted the local pharmacy to raise concerns about a delayed prescription for one person. They had advocated strongly that the matter needed to be addressed as a priority. 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, "I have a great rapport with my carers and we have a laugh and a joke." Another said, "Absolutely, we have an excellent relationship and a good banter as we know each other really well. They also chat away to the rest of the family and always remember to wish us a happy birthday when it is the right time". A third person said, "I love my regular carers, they are like sisters to me, if I am down in the dumps they try to cheer me up". One relative told us, "Even though mum can no longer speak, they do still try and talk to her and try and make her smile" Another said, "Some are like good friends to my wife and she tends to natter to them quite a lot". Staff told us how they tried to make time to chat with the person they were supporting. One staff member said, "It's important, we could be the only face they see all day".

People had been involved in planning their care and had been given the opportunity to say how and when they would like their care to be provided. If a person's preferred time was not available, staff tried to adjust this as soon as able. For example a relative told us that their family members visit was initially scheduled at 11am, but that this was too late for personal care. They told us they had raised this with the service and it was now at 7.30am which was perfect. Most of the people we spoke with felt that the service would take their views into account wherever possible, although a number did tell us that they had not been asked to express a preference about the gender of their care worker. For example, one person told us, "I have had to tell them I don't want male carers they never asked me". When a preference was expressed, people told us this was respected.

Where able, people had signed their care plans which confirmed that they had been involved in drafting the plan and had been given full and detailed information about the service. 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 clearly showed how they could raise any concerns or complaints.

Care workers understood the importance of encouraging people to remain independent. One care worker told us that the best part of their job was "Enabling people to stay in their homes". They told us about one person who had recently returned home from a long stay in hospital where they had become withdrawn and had stopped communicating. They explained that they had now been home a week and were now "talking, eating and singing". The staff member had arranged for an occupational therapy assessment to be made so that additional equipment might be put in place to enhance their ability to be even more independent. People confirmed that their care workers helped and encouraged them to be as independent as possible. One person said, "They help me into the shower I can wash myself. So they leave me until I bang on the floor and then come back and help me dry myself." Another person told us, "Yes staff do encourage me to be as independent as possible, in fact I have improved so much I only have the carers twice a week now instead of twice a day".

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, "Very much so. They treat me as I would like myself". A relative said, "Neither my mum nor my sisters have had concerns about this. They always ensure doors are shut and curtains closed when doing her personal care". Another relative said, "They are very respectful to my wife and they protect her modesty when washing her."

Requires Improvement

Is the service responsive?

Our findings

Our last inspection had identified concerns about how responsive the service was to people's individual needs. People had raised concerns that they did not always receive their care and support when they needed or wanted it and about the consistency of their care workers. This inspection found that whilst some improvements had been made, the service was not yet providing a consistently responsive service. For example, some people still felt more could be done to ensure that staff arrived on time, to ensure that they were kept informed about which care worker was coming and to ensure that new care workers were introduced to them before they started providing their care. Some people also told us that, at times, their care workers needed to rush. For example, one person said, "It is a bit of a rush but I know they have other jobs to do, if they are behind I let them go". A relative told us that care workers did not always have time to ensure their family member drank all of their drink before needing to leave. In most cases the length of time allocated to each visit was set by the commissioners of people's care and we were able to see that where staff had identified that care visits needed to be adapted or additional support put in place, staff had contacted adult services to advise of this.

Other people told us they were seeing some improvements. For example, one person said, "I do now [have consistent care workers] I have some lovely ones who tend to come to me". Another said, "We did have a dodgy time, but now we have a set few". We also received similar feedback from some relatives. One said, "We are now getting consistent carers, we are in a nice routine, they get to know her little ways". The manager advised that they and the co-ordinators were working hard to review the schedules and we were advised that approximately 79% of calls were currently rostered to be carried out by regular care workers and further improvements were planned. Schedules were being sent out earlier in the week to ensure people received these on time. These improvements needed to be embedded and sustained but there was a growing confidence amongst service users and the staff team that the manager was taking action to improve the service provided for each person.

Each person had a care plan which detailed the level of support they needed. Some people only needed support with meal preparation or with administering their medicines. Others required support with all aspects of their personal care including moving and positioning, support to eat and drink and skin care. The care plans had recently been reviewed and updated along with the person and their relatives; this had helped to ensure they were more accurate, reflected the person's current needs and reflected the person's preferences about how their care should be delivered. For example, people's food preferences were recorded and how they liked to take their medicines. Records made reference to when people preferred to get up and the clothes they liked to wear. Staff were reminded to 'Talk to people throughout their visit and involve them in what they were doing.

Daily records were maintained which provided basic details of the support that had been provided at each visit. We were able to see records which showed that staff regularly contacted the office to share concerns that people might be not be eating well or might be developing skin damage. This was confirmed by the people we spoke with. One person said, "They [the care workers] are very kind and caring, when I am not well, they get in touch with my family and if it is necessary they will phone my GP". People were offered

reviews annually or in light of changes in their circumstances. A relative told us, "We have had reviews at six monthly intervals, but if I need one in between, I get one". A person said, "I recently had a review of my needs and changes were made to the plan to reflect an improvement in my ability to do more for myself". Another relative said, "We had a review six months ago, we went through everything and reached a consensus". Following a number of recent reviews, we were told that staff had recognised that a number of people were becoming socially isolated and so five referrals had been made to the local authority with a view to these people being considered for a day service. People told us that staff tried to accommodate their changing needs and were flexible about cancelling or bringing forward visits.

There were systems in place to seek people's views and opinions about the service provided. An annual satisfaction survey had taken place in October 2016. The provider had analysed the results of the survey and provided the branch with an improvement plan. The main areas for improvement at that time had been, the consistency of care, people feeling they were involved in their care and the helpfulness of the office when contacted. The feedback we received during this inspection indicated that people were beginning to see improvements in most of these areas.

The service had a complaints policy and information about how to raise concerns or complaints about the quality of care provided was included in the service user guide which people had in their homes. We looked at the complaints log which contained only one formal written complaint since the date of our last inspection. The complaint from February 2017 had been investigated and responded to appropriately. The manager told us that verbal complaints were not currently logged in the complaints folder but on the individual person's care plan. They planned to change this practice, making sure that each complaint or comment was clearly captured and recorded so that any themes or trends could be identified and used to drive improvements.

Requires Improvement

Is the service well-led?

Our findings

Feedback from people about how well led the service was, was mixed. Some people told us the service needed to be more organised and that their concerns or issues were not always dealt with effectively. For example, one person said, I don't particularly think the office is well led, they seem to have retention and recruitment problems, as far as managers are concerned….their promises don't materialise, why can't they be more realistic and not make promises they can't keep".

People and staff told us that more could be done to improve communication. One person said, "They say they will get back to you and don't, I find it easier to just speak with the carers instead". Staff told us they would ring the office to advise that they were running late so that their subsequent clients could be informed only to find this message had not always been passed on. We spoke with the manager about this. They had already identified that communication was an area which needed to improve and they had restructured staff roles and responsibilities to address this. They had also invited people and their relatives to a coffee morning to introduce themselves to people and their relatives and a newsletter was being prepared to provide people with updates about staffing for example.

Some people and staff told us they were seeing improvements. One person said, "I do now [think the service is well run] but it has been chaotic before". Another said, "There have been a lot of changes of managers within the agency and this has caused problems, but I met the new manager last week and I felt she was very approachable". A third person said, "The previous manager wanted everything done his way and not how the clients or carers wanted, this new manager appears to be taking more notice of the carers and clients". Most of the people we spoke with told us they would now recommend the service, albeit with a recognition that there was still room for improvement.

Staff told us the manager was effective, approachable and had an understanding of the challenges faced by the service. They expressed a growing confidence that the new manager would continue to make improvements. One care worker said, "They are doing a brilliant job, they are willing to go out and do care, they are trying to keep on top of the training". Another said, "They are fair and professional, they have a different approach, if staff are not doing something right, they explain this to them, work with them to change what is wrong". A third care worker told us the manager was "The best thing to happen to the branch in a long time, they are approachable, we are very happy, morale has improved tenfold, carers are coming in more often to talk with us, passing on information, it wasn't happening before, the whole atmosphere is a lot better". All of the staff we spoke with gave similar feedback telling us they enjoyed coming to work, that there were fewer examples of staff handing back calls, demonstrating a greater commitment to the role and the people they were supporting. A recent staff survey had seen a 47% increase from the previous year in respect of the whether staff agreed there was a strong feeling of team work and cooperation. There had also been significant increase in staff satisfaction with the training and supervision provided and with the staff meetings which served as an opportunity to discuss any concerns they might have but also to develop their skills. A social care professional told us, "The constant changes within management in Agincare locally and in the wider region do not help, but we are hopeful of maintaining a good working relationship with the current manager who appears responsive and positive".

Audits were carried out to check on the quality and safety of the service provided, but these were not yet being fully effective at driving improvements. For example, audits of staff files had not identified the concerns we found in relation to the robustness of staff recruitment checks. However, it was evident that the robustness of audits in general was improving since the current manager was employed. For example an audit of care files in March 2017 had identified issues around record keeping. At a staff meeting in April, the registered manager had raised this and explained in detail her expectations regarding good record keeping and the importance of this to keeping people safe. The provider undertook quality monitoring visits to the service with the last one being in May 2017. Again the audit report had identified a number of areas for improvement and an action plan had been drafted with this due for completion by the 20 July 2017. Other systems were being used to assess and monitor the quality of the service. The field care supervisors undertook spot checks or observations of care workers to ensure they were delivering appropriate care, wearing the correct uniform and following correct infection control procedures.

The manager was relatively new in post but with the support of the deputy manager had already developed an understanding of the challenges faced by the service and the areas that required improvement. Records showed that they were proactive in tackling areas that required improvement such as communication and staff logging into and out of care visits. The manager was throughout the inspection receptive to feedback and clearly demonstrated a commitment to openness and transparency. They promoted a culture of honesty and of learning from mistakes. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment provided to people.

During the inspection we spoke with a representative of the provider. They told us they were proud of the improvements the manager was making despite only being in post for four months. They expressed a commitment to supporting the manager to continue to drive improvements through the ongoing support from the organisations quality assurance manager and through managers meetings where the senior team could share knowledge and reflect upon what was working well in order to make positive changes. They explained that as a provider they were aiming to put in place strategies and systems that would support ongoing recruitment and make Agincare the 'employer of choice'. They hoped to achieve this by promoting training through the use of an online training portal that staff could access when convenient. Trials were underway using new technology to support the delivery of care. They were providing a 'rising stars' programme which was a development initiative aimed at equipping staff with the skills needed to become managers in the future. Work was also underway with commissioners to look at different models of care that were more focussed on outcomes that were meaningful to people.

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 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.