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?	Requires Improvement
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 11 and 12 April 2016 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 149 people using the service at the time of this inspection. Approximately half of these people were receiving care under the REACT scheme. The REACT service is a reablement service offering time limited support, usually for up to six weeks, that is designed specifically to maximise the person's independence and abilities which have been lost through deterioration in their health or following hospital admission. This care is provided under a contract with the local authority.

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 January 2016 and was currently applying to the CQC to become registered. Prior to this, the service had experienced 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 to the staff team.

Recruitment of care workers remained a significant challenge and this meant that some people did not always receive consistent care in line with their individual needs and preferences.

Further improvements were needed to ensure that each person had a care plan which provided detailed information about their needs and supported staff to deliver responsive care.

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

Staff did not have all of the training relevant to their role and they had not been receiving regular supervision. This is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The new manager was taking action to address this.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect. They understood their responsibility to report abuse. However it was not clear that following two safeguarding concerns, that remedial actions were taken which prevented the risk of further harm or which were in line with the provider's policy and procedures.

Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed. Incidents were not always being effectively used as an opportunity for learning or to change practice.

People were happy with the support they received with their medicines. Medicines administration charts had been completed accurately and did not contain any gaps or omissions. However, staff were not confident about the provider's policy for administering PRN or 'as required' medicines or about how they should act upon verbal instructions from people's relatives about changes to medicines. We have made a recommendation about this.

People were supported to make their own decisions and where they lacked capacity to do so, care staff ensured the legal requirements of the Mental Capacity Act (MCA) 2005 were met.

People were asked about what assistance they needed with food and drinks when the service assessed their needs. Care workers were aware of people's dietary needs and were able to tell us how they would identify whether a person might not be eating and drinking in sufficient quantities to maintain their wellbeing.

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. People felt at ease with their care workers who had developed positive caring relationships with them.

The manager had an ethos of honesty and transparency. They demonstrated a passion for delivering a more personalised service to people and for supporting and developing the staff team. Staff told us moral was improving and that the new manager was approachable and supportive. They expressed a growing confidence that the new manager would continue to make improvements.

We found three breaches 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 was not always safe.

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.

Staff had received training in safeguarding adults and had a good understanding of the signs of abuse and neglect. However it was not clear that following safeguarding concerns remedial actions were always taken which prevented the risk of further harm or which were in line with the provider's policy and procedures. Some risk assessments needed to be more robust and include more detailed guidance about how the identified risks were to be managed.

Improvements were needed to ensure that there were at all times sufficient numbers of staff to meet people's needs and preferences in a consistent manner.

People were happy with the support they received with their medicines. However, staff were not confident about the provider's policy for administering PRN or 'as required' medicines or about how they should act upon verbal instructions from people's relatives about changes to medicines. We have made a recommendation about this.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff had not received appropriate support, training, professional development and supervision to support them to carry out their role effectively.

People were supported to make their own decisions and where they lacked capacity to do so care staff ensured the legal requirements of the MCA 2005 were met.

People were supported with their health and nutritional needs.

Is the service caring?

Good

The service was caring.

People were treated with kindness. They were supported to express their views and were involved in decisions about their care was to be delivered.

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

Is the service responsive?

Requires Improvement

The service was not always responsive.

Recruitment of care workers remained a significant challenge and this meant that some people did not always receive consistent care in line with their preferences.

Further improvements were needed to ensure that each person had a care plan which provided detailed information about their needs and supported staff to deliver responsive care.

Improvements were needed to ensure that complaints were effectively managed and were used to drive improvements.

Is the service well-led?

Requires Improvement

The service was not always well led.

People felt the service needed to be more organised and that there needed to be more effective communication between staff and people using the service.

People and staff had the opportunity to give feedback about the service, however were not always able to see that this was acted upon. Audits were not yet being fully effective at driving improvements.

The manager demonstrated a passion for delivering a more personalised service to people and for supporting and developing the staff team. Staff told us moral was improving and that the new manager was approachable and supportive. 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 11 and 12 April 2016. The inspection team consisted of a lead inspector, a second 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 new manager and staff. The second inspector conducted telephone conversations with staff employed by the service and visited people in their homes. 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. Prior to the inspection we also sent out questionnaires to 50 people, asking them for their views about aspects of the service they received. Eighteen questionnaires were returned and some of the feedback from these is shared in this report.

During the inspection we spoke six people who used the service by telephone. We also visited six people in their homes and spoke with them about their care and support. We spoke with the new manager and deputy manager, a care co-ordinator and 12 care workers. We reviewed the care records of four 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 sought feedback from three health and social care professionals and asked their views about the care provided by the service.

The service was last inspected in June 2014 when no concerns were found in the areas inspected.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe when being supported by the care workers. One person said, "I feel safe, [the care worker] is wonderful". Another person said, "Yes I have lost my balance and they look after me". A relative told us, "I think it is fair to say [the person] feels safe".

Improvements were needed to ensure that appropriate recruitment checks took place before staff started working at the service. Records showed staff completed an application form and had a formal competency based interview as part of their recruitment. Checks had been made with the Disclosure and Barring Service (DBS) to ensure the staff member had not previously been barred from working in adult social care settings or had a criminal record which made them unsuitable for the post. However in two of the records we reviewed, a full employment history had not been obtained. This information is important as it allows relevant background checks to be undertaken. We spoke with the new manager about this and they obtained the information during the inspection. In one care worker's file there was just one reference which did not provide satisfactory evidence of their conduct in previous employment. Another person did not have a recent photograph as proof of their identity. The provider had not ensured that all of the required checks were completed before new staff members started work. This is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Fit and proper persons employed.

Risk assessments were not always sufficiently robust. Basic risk assessments were in place for moving and handling, falls and medicines. However, we noted that some of the risk assessments lacked detail or clarity about how the identified risk was to be managed. For example, one person was noted to be at risk of falling from bed as they did not have bed rails. There was no further detail about how this risk might be better managed. Another person's care plan recorded that they were at risk of 'self-neglect' but there was no information as to what was meant by this or again how the risk could be managed. Many of the risk assessments were not dated or signed. For example, one person's falls risk assessment had identified that the person was at high risk of falls and therefore should be reviewed monthly, but we were unable to tell whether this review was overdue as the assessment was not dated. We spoke with the new manager about our findings. They had already identified that some of the risk assessments were not sufficiently robust and we saw that a plan was in place to review and update all of these which they hoped would be completed by June 2016.

Some of the risks to people's and staff health and safety were appropriately managed. For example people's care plans contained general health and safety risk assessments which considered a range of environmental risks. This identified any risks that staff faced when working alone in people's homes such as poor electrics or because the visit was to take place in an isolated area. The staff we spoke with were able to describe the actions they would take if, for example, they were unable to gain access to a person, and they appeared confident with dealing with emergencies such as finding that a person had suffered a fall or was unwell. 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. 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 an 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.

Incidents that affect the health, safety and welfare of people using the service, should be reported internally and where relevant to external authorities. The incidents should be investigated and remedial actions taken to help prevent further occurrences and to promote learning. We reviewed the incident log and found that there was no record of any incidents prior to January 2016 which is when the new manager started. It is not clear whether there had not been any incidents or whether these had not been logged. A review of the incidents reported since January 2016 showed that in most cases the incident had been investigated although the records relating to these were not always fully completed and it was not clear that where actions had been recommended that these had been completed. We could not therefore be confident that incidents were being effectively used as an opportunity for learning or to change practice or update people's care records. This is an area for improvement.

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. Relevant contact numbers for the local authority safeguarding team were displayed within the service. Arrangements were in place to protect people from the risk of financial abuse. For example, when a care worker undertook shopping on behalf of a person, a log of the transaction was maintained in the person's care plan and the receipts kept. The organisation had a policy that staff must not have access to people's banking pin numbers and this was confirmed by the staff we spoke with. However, some areas required improvement. We were aware that the local authority safeguarding team had not received a timely response to two safeguarding concerns that had been raised about people using the service. This was before the new manager had started and the concerns have now been addressed. However, we also noted that one recent incident of unexplained bruising had not been escalated to the local authority and following a different safeguarding concern in March 2015 the new manager had not ensured that the remedial actions taken were in line with the provider's policy. Improvements are needed therefore to ensure that the new management team understand their responsibilities to use relevant systems and processes effectively to safeguard each person using the service. 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.

Improvements were needed to ensure that there were at all times sufficient numbers of staff deployed to meet people's needs. People told us they received their essential care, but that this was not always at a time of their choosing or provided by consistent staff. A social care professional told us that they commissioned a specific number of care hours from the service, they said, "Agincare, have struggled to achieve these hours consistently as a result of recruitment issues". Staff told us that the current staffing levels did not provide adequate contingency to cover care workers that were ill, or on leave, or those who chose not to work at times due to being on zero hours contracts. A number of care workers told us they were often asked to cover calls or felt the need to rush when providing care. None of the staff we spoke with felt that this placed people's safety at risk but did impact upon them being able to deliver person centred care at times.

At the time of the inspection there were 40 staff supporting a total of 149 people. Staff employed included the new manager and deputy manager, an administrator and two care co-ordinators that were responsible for the day to day scheduling of the care visits. There were three field care supervisors who were responsible for keeping people's care plans up to date and for carrying out spot check or competency assessments with the care workers. The new manager acknowledged that the service faced an on-going recruitment challenge. However, they told us, and people confirmed that there had been no recent missed care visits. The new manager said they always managed to provide staff to support people, even if at times this might

be later than planned if there had been an emergency or staff had called in sick. They told us that recruitment remained a priority and that this was an area they intended to focus on in the short term. They were confident that the current number of staff was in line with the number of care hours they were currently delivering and they were clear that the service would not expand or accept new requests for care until there were additional staff in post.

The provider had a clocking in system which provided alerts to either office staff or the on call manager if a care visit was not logged as completed by care workers. This meant that missed or late calls could be monitored and appropriate action taken and the on call manager could check on the welfare of staff lone working late at night. The effectiveness of this system was, however, currently limited as only 30% of care workers were using the system. The provider was working with the staff team to increase the use of call logging to help ensure that this system provided an effective safeguard against the risk of missed calls and helped to manage the risks associated with lone working for staff.

People were happy with the support they received with their medicines. Most of the people we met either managed their own medicines or had a relative who assisted them. Where support was 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. We reviewed one person's medicines administration records (MAR) and found this had been completed accurately and did not contain any gaps or omissions. Staff were clear about what action to take if a person refused their medicines. A staff member told us, "I would record if someone refused their medication, I would try and encourage them, but if they wouldn't I would tell the office and record it on the MAR. We did note that staff were not confident about the provider's policy for administering PRN or 'as required' medicines or about how they should act upon verbal instructions from people's relatives about changes to medicines. There was therefore a risk that they might act outside of the provider's policies and procedures and not in line with best practice.

We recommend that the provider ensures that staff are acting in accordance with relevant guidance from the National Institute for Health and Care Excellence (NICE) when managing people's medicines.

Requires Improvement

Is the service effective?

Our findings

People told us they were generally satisfied with the care provided. One person said, "I can't grumble, I think they do a good job, the lady that came this morning, she's excellent". Another person told us, "I think they are well trained, sometimes [member of staff] comes around and spot checks them". When asked if their care workers were well trained another person told us, "It varies, they do things differently, but I tell them how I like things to be done. When they are new I give them a bit of leeway to learn the job". Staff felt the training provided was adequate. Comments included, "I get enough training to do my job" and "I get the right amount of training to manage what I do". A relative told us, "They [the care workers] seem to know what they are doing". A social care professional told us staff "Required a lot of support from us when dealing with service users with complex re-ablement needs".

Whilst staff told us their training was adequate and people felt their care workers were suitably skilled, we found that some staff did not have all of the training relevant to their role. The manager 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, infection control and managing medicines, despite the provider requiring these to be completed on an annual basis. For example, we noted that at least eleven staff that were supporting people with moving and handling tasks did not have up to date moving and handling training. The manager told us that these staff would be required to complete this within the next two weeks. At least six staff had not undertaken their annual refresher training in managing medicines and had not had an annual assessment of their competence to administer medicines safely. Twenty two staff had not had an annual refresher in safeguarding training. We were concerned that this meant there was a risk of people receiving care from staff without the appropriate skills and knowledge. Staff had not undertaken additional training relating to the specific needs of people using the service. For example, staff had not undertaken training in the Mental Capacity Act (MCA) 2005 or in managing behaviour which might challenge others. Staff did not have all of the training relevant to their role. This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Staffing.

Supervisions had not been taking place in line with the provider's policy. Two staff told us, they had not received supervision in over two years. Staff complained of just 'plodding along' 'doing their best'. Others said that in the absence of a manager, the deputy manager and office staff had been supportive. One care worker said, "If we had any problems we could just go in and speak with someone". Another said, "I can always ring someone in the office, they are pretty good". Supervision can be done in a variety of formats and can be a formal one to one session with a care worker or an observation of their practice. It is important as it helps to ensure staff receive the guidance required to develop their skills and understand their role and responsibilities. The new manager was taking action to address the lack of supervision and with the support of the senior team was undertaking competency checks with staff to monitor their abilities in areas such as moving and handling, medicines management and general care practice. They had also started to undertake appraisals with staff which were well documented and explored the staff member's performance, and training needs. A staff member told us, "I've had a one to one supervision with the manager recently, all the other managers I didn't have one with, I feel supported by the company". This process will need to be embedded in practice and sustained in order to ensure that staff receive appropriate professional

development, supervision and appraisal.

Staff undertook an appropriate induction which prepared them for their role. New staff completed a three day induction programme 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. A care worker told us, "During induction I did all of the training and I got shadowing. We were told we could have more shadowing if we wanted, we just had to ask".

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. Where required, 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 appropriate consultation had been undertaken with relevant people, to ensure that the care plan being delivered was in the person's best interests. Some of the care workers we spoke with were less confident about the MCA 2005 and said they had not received training in this. This is an area that could improve. Where people were able to make their wishes known, their choices were respected. A care worker told us, "I always ask people if it is okay or if they are happy for me to provide care". Another said, I would ask people if they were happy to have care, if they refused I would try and encourage, if they were adamant, I would make a note and inform the office, I wouldn't force anyone to have care". Many care plans contained signed consent forms which confirmed that the person had been involved in planning their care and that their views and preferences had been taken into account.

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. One person told us, "On Friday I got a sausage sandwich, when [my care worker] got here, they came in and said, 'you couldn't give a sparrow that' and she went and got me fish and chips it was lovely". Most people were able to eat and drink independently once the meal was prepared. A relative of one person who did need assistance to eat and drink told us, "the carers do breakfast and lunch, they need assistance, they don't rush them with their food". 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 raised 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. A care worker told us, "I will get the district nurse if catheters are blocked or if people have broken skin". Care workers told us that if a person was unwell they would call out the GP and pass on their concerns to the office and to the person's family. One said, "I would report anything, if a person had marks on them, or they were eating and drinking, anything if they weren't their normal self".

Good

Is the service caring?

Our findings

People told us their care workers were kind and caring. One person said, "The carers are very caring, very friendly". Another person said, "They are very kind and considerate. A third person said, "They are very kind, they know my needs, they notice if I'm a bit down". A relative told us the care workers were "Not rude at all". We saw that one person had commented in a recent telephone survey, "I love the girls that care for me". A member of staff told us, "The staff are all kind and caring, they are brilliant, their hearts are in the right place, they go above and beyond, the service users mean the world to them, if my relative needed care I would have no concerns about it being provided here". We saw that a social care professional had recently fed back to the service that they had found a person's regular carer workers 'Effective and professional whilst still providing care in a person centred manner'.

People and their relatives told us they had developed positive relationships with their regular care workers. For example, a relative told us, "In general we are happy…the majority of the time it's the same carers they are fantastic….they focus on her needs rather than time, they make sure her welfare is paramount". Staff told us how they tried to make time to chat with the person they were supporting and tried to display empathy with them. One care worker said, "When I get a new service user….I ask them about their routines and preferences". This was echoed by another care worker who said, "I try to chat with people whilst doing tasks, you find out about them by talking with them". A number of care workers told us that communicating with people was an important part of developing a relationship with them. A care worker said, "I have empathy with people, communication is very important, making sure people are safe, treating people as if they are your own". Some people spoke of concerns about not receiving consistent carers which made providing person centred care a challenge. For example, a relative told us, "You have to know how to speak with [their relative] not all of them understand that".

We saw evidence that people had been supported to express their views about how they would like their care to be provided. When people first started receiving the service, they were visited at home so that their care plan could be drafted. Together with the person, staff identified the care that was to be provided and the tasks that were to be completed at each visit. The manager told us, "We try to ensure that the person receiving help has control over their care". 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.

People told us their care workers helped and encouraged them to be as independent as possible. For example, one person said, "They encourage me to do things; they have a laugh and a joke with me" and another said, "Yes they help me do the bits I can't do and let me do the rest". "Care workers understood the importance of encouraging people to remain independent. One care worker said, "I don't take over and let people do as much as they can for themselves. Its about supporting and encouraging people, sometimes people who have come out of hospital come on in leaps and bounds in a week". 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. A care worker said, "It's about dignity, asking what they want, asking if they are comfortable".

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people as to how responsive the service was to their individual needs. People who had regular care workers said staff knew them and their needs well and attended at a time of their choosing. A relative told us that their mother usually had regular carers who were able to "Monitor her wellbeing and pick up if she is unwell". However, some people raised concerns about not receiving a consistent set of care workers who were able to get to know their individual care needs and preferences. People's comments included, "They send people we haven't seen before, we get so many different ones", "They keep chopping and changing" and "Sometimes I think they pick the names out of hat, I usually get [care worker] in the morning and [care worker] in the afternoon, the midday is a pick and mix". A relative told us, "They have new carers all the time, we would prefer permanent carers…I have to explain everything over and over again to the carers, two new carers came this week".

Whilst some people told us their care visits were punctual and lasted for the correct amount of time, others told us that they did not always receive their care and support when they needed or wanted it. For example one person told us their care workers sometimes called at 7pm to help assist them to bed when they were meant to visit at 9pm. They said, "No way am I going to bed at 7pm, sometimes, they go and come back". The care worker's schedules factored in five minutes of travelling time between each visit. Again staff were mixed in their views as to whether this was sufficient. Some staff said that this was sufficient to complete each call and travel to the next person. Others said the lack of adequate travel time meant they were playing catch up all day.

People told us that they usually received a rota each week which listed which care workers were covering their visits. However, a number of people raised concerns with us that the rotas were not always accurate or contained gaps. For example, we saw that one person's rota did not have a care worker allocated as yet for their care on Sunday. Their relative said, "I have had to phone them up and ask who is coming". A person told us, "It says one carer on the rota and another carer turns up, it happened this morning". They said that they were not always advised about such changes in advance which was unsettling. A relative raised concerns with us that the timing of care visits was erratic. We looked at their relative's rota and saw that the morning visit was scheduled in at a variety of times during the week of our inspection. For example, one day it was scheduled for 10.40am and another for 9.20am. The person's relative told us that when staff came early they had to interrupt the person's breakfast so that they could receive their care. This impacted upon staff being able to provide care in a person centred manner.

Staff told us that there were not enough care workers to provide consistent care. One care worker said, "I think it is very short staffed, I often get asked to cover calls". Another care worker said, "There aren't really enough staff to give adequate cover, for example, if people go of sick". Some staff complained of feeling rushed and of not always having time to complete all of the required tasks. One care worker told us they had raised their concerns, they said, "We are rushing in and out, we are supposed to be watching how people rehab, you don't get time to see if they walk up the garden". Some staff described how the challenges around staffing and recruitment could at times impact on people's dignity. For example, one care worker said "Many of the service users don't know which carer is coming to them…they often ask me, do you know

who is coming tomorrow". A social care professional told us, "our experience is that the care staff appear to attempt to ensure that service users are treated [with dignity and respect] but feedback from my staff that have engaged with Agincare staff suggests that they are allocated a large number of service users in a shift so this hinders their ability to be able to work in this manner".

Thirty seven per cent of the people that responded to our pre-inspection questionnaires said that staff did not arrive on time. Twenty eight per cent of people said they did not receive consistent care. We spoke with the new manager about people's concerns; they explained that recruitment of further care workers remained a significant challenge for the service. They advised that whilst new staff were being recruited they were not taking on any new service users so that they could make improvements and concentrate on providing a more consistent and responsive service to their existing clients.

The provider had not ensured that people were consistently receiving a service that met their individual needs and reflected their preferences. This is a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated activities) Regulations 2014. Person centred care

A number of staff raised concerns with us that the length of time allocated to some people's calls was not sufficient. One care worker told us, "It means things don't get done, for example, people do not get shaved". Another care worker said that the amount of time allocated meant that they weren't have to have a chat, a third said that it meant people were encouraged to be independent, for example, walk through the bathroom, rather than be wheeled. We are aware that the amount of time allocated to a care visit is determined in many cases by the Local Authority and not by the service. We were able to see evidence that where staff had identified that care visits needed to be adapted or additional support put in place, the new manager or care co-ordinators had contacted adult services to advise of this. For example we saw that staff had identified that a person would benefit from longer visits to support them with their continence needs. The new manager had contacted adult services and requested that the existing visit be increased. We saw a letter of thanks from the person's daughter with regards to this.

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 that people received when they first started using the service. People told us they were comfortable about raising any issues, but some people felt their concerns or issues were not being dealt with effectively. Three people told us that communication from the office based staff needed to improve. They said they had raised concerns about late calls, or about not knowing which care workers were going to be visiting. They told us the response was often, 'we've got a lot of staff on holiday' or 'they are on their way'. One person said, "I've told them I don't need Friday lunch call many times, they still send them, I would like to know who is coming and what time, I would like a rota, I have complained to the office about timings, they said they've got a lot on". Thirty six per cent of people who replied to our pre-inspection questionnaires stated that the office did not respond well to their concerns or complaints.

We looked at the complaints log which contained nine complaints since October 2015. Most of the complaints had been investigated and responded to in a timely manner. However, the records relating to other complaints or concerns were incomplete. There were some complaints in a complaints folder which were not logged on the provider's electronic complaints recording system and vice versa. We were concerned that this would mean that the provider and new manager did not have a full overview of the complaints made, of any patterns or trends and use these to drive improvements. This is an area for improvement

Records relating to people's care were not always accurate or sufficiently detailed. 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 information in some of the care plans we viewed lacked detail or contained inconsistent or unclear information. For example, one care plan we saw said that the person was very independent and managed their own personal care, but later said that staff were to 'assist with a full strip wash'. We reviewed the care plan of one person who staff had told us could at times display behaviour which could challenge others. There was no reference in the person's care plan to this or how staff should manage the behaviours. In one of the care plans viewed during our visits to people in their homes, we found an Agincare form which stated in bold, 'This is to confirm that a senior health care practitioner has made a DNACPR (Do not attempt cardio pulmonary resuscitation) decision in respect of the above named person'. The forms were meant to serve as a record of whether the person had such a decision in place. The form had not been completed and so it was not clear to us whether the person had a DNACPR decision in place. If no decision was in place, we were concerned that staff could mistake this form for a valid DNACPR decision and not provide life sustaining treatment in the event of the person experiencing a cardiac arrest. We have asked the manager to review how this form is used.

We did see some care records which provided more comprehensive information about people's needs and how these were to be met in line with their preferences. For example, one care plan contained a pen profile which described the person's history, their strengths, social network and likes and dislikes. People's food preferences were recorded and how they liked to take their medicines. We saw that one person enjoyed using their computer and another playing a musical instrument. People were described by their preferred name throughout their care plans. This information is important as it helps to ensure that staff have the information they need to develop positive relationships with people living in their own home and provide responsive care. A care worker told us, "Since we have had the new manager, they are really getting up to date with the care plans". Another said, "The care plans are improving, they've had a few people come out of the office to do specific care plan updates, they have got them to a better standard, they were out of date due to co-ordinators leaving, they have a good team in now that are committed to doing it".

The manager told us they had already identified that people's care records needed to be more detailed. They explained that all care plans were being reviewed and updated to help ensure that they provided detailed step by step instructions for providing personalised and responsive care. This is a work in progress. The manager told us that they anticipated that each person's care plan would have been reviewed and updated by June 2016.

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. We observed that one carer called the office to report that a person had fallen. The care worker was told to stay with the person until the paramedics arrived. Office staff then began calling the care workers subsequent clients to explain that their care visit would be delayed.

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. One person said, "I can't fault the carers, but I don't think the office is organised". Another person said, "I would say they are well organised 80% of the time". Another person said, "They need to do management better, be more courteous and the office needs to buck up". People gave us mixed views about whether they would recommend the service to others with their common concerns being about the lack of consistent care workers and the not receiving a rota each week. A relative told us Agincare were "Considerably better than the previous agency. I think they are probably as good as most". A social care professional told us, "There have been a large number of management and staffing changes with all levels of management during the short period….This has presented a challenge for us with establishing positive service management relations".

People told us that communication was an area which they felt could improve. They expressed a frustration that it could take a long time for their calls to be responded to. We fed this back to the new manager. They explained that the past year had been challenging. There had been no consistent manger in post and recruitment had been an ongoing challenge which meant that the office staff were often called upon to deliver care and so were not available to answer calls and update care plans and records. We saw that the new manager was trying to improve communication with people using the service. A newsletter had been sent out in March 2016 which provided people with updates about staffing issues and about plans to update each person's care plan. The new manager used the newsletter to introduce herself and to encourage people to contact the office team with questions or concerns about their care.

Staff were positive about the new manager. They told us the new manager was approachable and supportive. They expressed a growing confidence that the new manager would continue to make improvements One care worker said, "Morale is getting there, it has been low, but now [the manager] has come along and is investing in us". Another care worker said, "Moral is getting better, [the manager] take matters on board". Staff also spoke positively about the deputy manager and office team whom they said worked hard to ensure all calls were covered and people received their care. When asked what still needed to improve, most care workers said that it was the staffing levels and the consistency of care provided to people. Many raised the issue of zero hours contracts and how these resulted in staff handing back work when they no longer wished to provide it which impacted upon the care provided to people. We discussed this with the new manager. They told us they were committed to retaining and recruiting more staff and for delivering a more personalised service to people. They told us "I try to ensure that staff feel valued, if you look after them, they will look after the service users". The new manager told us that schemes such as carer of the month and other incentives were being introduced in an attempt to demonstrate the provider's thanks to its staff for all of their hard work supporting the service.

People and staff had the opportunity to give feedback about the service. Office staff completed telephone surveys with people on a regular basis. 15 people had been contacted for their views on their care in February 2016 with the majority of the feedback being positive. An action plan had been drafted in response to any areas which required improvement. Annual satisfaction surveys were undertaken with people, their

relatives and with staff. The most recent surveys had been in April 2015. The provider had analysed the results of the surveys and provided the branch with an improvement plan which included the requirement to use the feedback in staff meetings to promote learning. We were not able to see however, that actions detailed in the improvements plans had in many cases been completed. This is an area for improvement, it is important as it helps to demonstrate that feedback from people is being acted upon and is used to drive improvements.

A number of 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, they had not identified the concerns we found in relation to the robustness of staff recruitment checks. The medicines audit completed in March had identified that work was needed to communicate to people and their relatives the extent of the role and responsibilities of care workers in relation to medicines management in the community. There was however, no clear action plan recording how this might be achieved. The provider undertook quality monitoring visits to the service with the last one being in February 2016. The audit report had identified a number of areas for improvement and an action plan had been drafted. We found, however, that a number of the actions had not been completed within the required timescale.

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. The new manager was throughout the inspection receptive to feedback and clearly demonstrated a commitment to openness and transparency. 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. They told us they also were being supported by the provider and other local Agincare branch managers with whom they were having a weekly teleconference to share knowledge and reflect upon what was working well in order to make positive changes. They had a clear passion for providing person centred care and told us they were committed to making the required improvements so that people received the very best care possible.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider had not ensured that people were consistently receiving a service that met their individual needs and reflected their preferences.

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.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not have all of the training relevant to their role.