Scott Care Limited

Scott Care Limited (Sittingbourne branch)

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

Overall summary

The inspection was carried out on 1July 2015. The inspection was unannounced. Normally we give 48hrs notice of an inspection to a domiciliary care agency. However this inspection was planned as an unannounced due to the concerns we had received from the public and social services.

Scott Care office is based in Sittingbourne and is easily accessible for staff, visitors, including people who may have a mobility disability. At the time of the inspection the service was providing support to 105 people who use the agency services regularly. Most people were funded by the local authority or through NHS continuing care services with a smaller proportion of privately funded people. The service is one of two domiciliary agencies run by the provider at this location. . The service is in the process of change with Scott Care (Medway) office joining them in the Sittingbourne office. This has entailed a lot of upheaval and resulted in a loss of some co-ordinating and care staff.

Summary of findings

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

The Care Quality Commission (CQC) monitors the operation of the Deprivation of Liberty Safeguards (DoLS) which applies to care services.

The agency was not accepting new referrals, due to the concerns that had been raised and the need for more staff. The agency was recruiting care staff to make sure there will be sufficient numbers of staff to meet people's needs and provided a flexible service. We have made a recommendation about this.

Concerns had been raised about individuals not receiving their medicines as prescribed. There had been incidents where medicines had not been given, or had been given late. The agencies system for recording medicines administered was not robust and did not show the actual medicines administered. Staff were being retrained and had to show competency before they could administer medicines again. We have made a recommendation about this.

People said that they knew they could contact the office at any time, but they felt that communication between the office and staff was not always effective. A complaints procedure was in place to ensure people's concerns and complaints were listened to, and addressed in a timely manner and used to improve the service. However, although people told us that they would be happy to make a complaint, half the people we spoke with said they did not have a copy of the complaint procedure. We have made a recommendation about this.

The agency had suitable processes in place to safeguard people from different forms of abuse. Staff had been trained in safeguarding people and in the agency's whistleblowing policy. Staff were trained in how to respond in an emergency (such as not being able to gain access to a person's premises or finding a person collapsed) to protect people from harm.

The agency had robust recruitment practices in place. Applicants were assessed as suitable for their job roles. Refresher training was provided at regular intervals.

All staff received induction training and they worked alongside experienced staff and had their competency assessed before they were allowed to work on their own.

The provider carried out risk assessments when they visited people for the first time which included an environmental assessment.

Incidents and accidents were recorded and checked by the provider to see what steps could be taken to prevent these happening again.

The provider involved people in planning their care by assessing their needs on the first visit to the person, and then by asking people if they were happy with the care they received.

People were supported to choose a healthy and balanced diet. Where care workers had identified concerns in people's wellbeing there were systems in place to contact health and social care professionals to make sure they received appropriate care and treatment.

Formal systems for monitoring quality and safety across the service had not been properly implemented at the time of the inspection. This meant that some opportunities to identify potential improvements had been missed, although the manager was able to demonstrate that she encouraged and acted upon feedback from people who used the service.

Whilst we found a number of areas which required improvement, the manager was able to provide evidence that she had also recognised them, and in most cases was also able to provide evidence that she had started to take action to address them.

Summary of findings

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.

Medicines was not always given and properly recorded in all cases.

Staff were not adequately deployed to meet people's needs due to staff shortages.

Staff were informed about safeguarding adult procedures, and were aware of appropriate actions to keep people safe.

The agency carried out environmental risk assessments in each person's home, and individual risk assessments to protect people from harm or injury.

Staff were recruited safely and the appropriate checks were made before any new staff commenced work with the service.

Is the service effective?

Good

The service was effective.

Staff received on-going training and supervision, and studied for formal qualifications. Staff were supported through individual one to one supervisions, spot checks of their care practice and appraisals.

People were supported to be able to eat and drink sufficient amounts to meet their needs.

Staff were knowledgeable about people's health needs, and contacted other health and social care professionals if they had concerns about people's health.

Is the service caring?

Good

The service was caring.

People felt that staff provided them with good quality care.

Staff protected people's privacy and dignity, and encouraged them to retain their independence where possible.

Wherever possible, people were involved in making decisions about their care and staff took account of their individual needs and preferences

Is the service responsive?

Requires improvement

The service was not always responsive.

People felt comfortable in raising any concerns or complaints but some people found their complaints were not always taken seriously.

Summary of findings

Visit times were discussed and agreed with people and the care plans contained details of the exact requirements for each visit. However, there were shortfalls around times of calls, and the lack of consistency regarding staff.

People's care plans reflected their care needs and were updated after care reviews or if people's circumstances changed.

Is the service well-led?

Requires improvement

The service was not always well-led.

The agency had a quality assurance system which identified shortfalls. However; these had not been addressed promptly to ensure that people always received a safe and quality service.

The service had an open culture. People were asked for their views about the service and their comments were being listened to and acted upon as on going.

The provider and manager were aware of their responsibilities.

The service had a clear set of values and these were being put into practice by the staff and management team.

Scott Care Limited (Sittingbourne branch)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 1July 2015 and was unannounced. Normally we give 48hrs notice of an inspection to a domiciliary care agency. However this inspection was planned as an unannounced due to the concerns we had received from the public and social services.

The inspection team included two inspectors and an expert by experience who contacted people who used the service by phone to gain their views on the service provided. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law.

During our inspection, we spoke with the manager of the agency and three members of staff coordinating care delivery from the office. Following the inspection visit, we spoke with eight care staff and 15 people who used the service or their relatives on the phone.

We also reviewed a variety of documents. These included eight people's care records and six staff recruitment files. We looked at records relating to the management of the service, such as staff induction and training programmes; staffing allocations and completed incident forms, as well as a selection of policies and procedures.

The previous inspection was carried out on 6 August 2014, we had no concerns and there were no breaches of the regulations.

Requires improvement

Is the service safe?

Our findings

People told us they felt safe receiving care from the staff at the agency. They told us they had no cause for concern regarding their safety or the manner in which they were treated by care staff. Relatives and people using the service said, “Oh yes I feel very safe” and “I think my mum is very safe, if the same carers come each time. When different ones come, I do worry about her”.

Care staff had received training to assist people with their medicines. They had been informed about the action to take if people refused to take their medicines, or if there were any errors. The agency had rightly notified the local authority social services and the Care Quality Commission (CQC) when errors had occurred.

Checks were being carried out to ensure that medicines were administered appropriately. The manager told us about two staff who had administered medicines incorrectly which substantiated the concerns made by the social services care manager. The provider had taken appropriate steps with the staff members receiving further training. The staff members then had to demonstrate their competency before they could administer medicines again to ensure there was no repeat of errors. We viewed one staff’s file where medicines training had been refreshed and the competency checked. All the staff we spoke with said that they had received training on medicines during their induction, and they had been observed administrating and recording medicines, before they had been able to administer it alone. We found that medicine administration was also being observed when spot checks were carried out to assess staffs practices in people’s homes. This took place to ensure that people received their medicines as prescribed.

The agency had made sure that medicines were supplied in a MDS (monitored dosage system) supplied by the local pharmacies where people lived. The MDS divides the medicines into daily amounts and separates them it to different times of the day. This enables the person or the carer to administer the medication more safely. Most pharmacies had also supplied a MAR (Medicines Administration Record) sheet with the medicines to be administered. The care staff had signed the MAR sheet for any medicine they had assisted people to take. When the pharmacy had refused to supply the MAR sheet with the medicines, staff recorded the medicines given on a record developed and supplied by the agency. However, the record sheet supplied did not contain all the information required. It did not name the medicines or state the time and amounts of medicines to be given. Therefore, there was no record of the actual medicines given to people and information that may be needed in an emergency for example. This meant that medicines could be given in error by staff thereby causing harm to the person.

We found that call times were not consistent so that people received their medicines on time and as prescribed. People we spoke with and the results from some survey forms showed they were not happy with the times of calls. Times are agreed with the person at the start of their care package. For some people the time is critical. For example, some medicines were given for pain management. People told us “Staff do not always arrive on time but they do ring me to tell me” and another person said “The timings are not good, sometimes they don’t arrive at all no one lets you know, I end up phoning them”. A relative told us “They can arrive anytime between 8am and 10.30am, which is not good as my mum lives alone and needs to have her medication” and another said “ They have ‘walkers’ who don’t drive and they are obviously going to arrive late”. It is important medication is given at the correct times, for example if the morning medicines are given late, it may mean the lunch time medicines could not be given or the person would have too much of a medicine in a short space of time.

We recommend that the provider seeks and follows the National Institute for Health and Care Excellence NICE guidance on managing medicines.

People were confident that staff had the knowledge to recognise and report any abuse. Staff we talked to were aware of how to protect people from abuse and the action to take if they had any suspicion of abuse. They understood the different types of abuse and how to recognise potential signs of abuse. Staff training in protecting people from abuse was part of their induction and there was on-going refresher training for safeguarding people. The service had the local authorities safeguarding protocol which staff could use to make sure they followed the correct procedure if they needed to raise an alert. The agency had processes in place to protect people from financial abuse. This included recording the amount of money given to care staff for shopping; providing a receipt; and recording the amount of change given. Where possible, any transaction

Is the service safe?

was signed by the staff member and the person receiving support, or their representative. This record provides an audit trail should there be any queries about the amount of money spent in the future protecting both the person and the staff.

Before any care package commenced, the provider and manager carried out risk assessments of the person's home, and for the care and health needs of the person concerned. Environmental risk assessments were thorough, and included risks inside and outside the person's home. For example, they carried out a visual check of electrical appliances that staff may use during their visits, such as a kettle. They would look to make sure leads were not damaged. They also look and document any trip hazards such as rugs or frayed carpet.

People's individual risk assessments included information about action to take to minimise the chance of harm occurring. For example, some people had restricted mobility and information was provided to staff about how to support them when moving around their home and transferring them in and out of their bed or a wheelchair. People were provided with equipment to support them such as hospital type beds and pressure-relieving mattresses. Exact instructions were given about how to use individual hoists, and how to position the sling for the comfort of the person receiving support. People who required hoisting to help them move from one place to another were always supported by two care staff working together. In this way, people were supported safely because staff understood the risk assessments and the action they needed to take when caring for people.

The manager ensured that required checks and servicing had been carried out for lifting equipment so that it was safe for staff to use. Staff told us that some people were provided with a pendant 'lifeline' which could be worn around their neck. They pressed the alarm if they had an accident or were seriously unwell. These are a 24 hour care system to alert on-call operators to obtain help for people. Care staff checked that people had their lifeline pendants in place before leaving the premises.

Care staff knew how to inform the office of any accidents or incidents. They said they contacted the office and completed an incident form after dealing with the situation. The manager viewed all accident and incident forms, so that they could assess if there was any action that could be taken to prevent further occurrences and to keep people safe.

Where people had the same regular carers visiting them, people were happy. One person said "Yes I have same carers most of the time, they know me and they are friendly, I look forward to their visits". This has not been the same for all the people receiving a service, another person said "I did have the same carers, it was good then, they knew where everything was and I looked forward to the visits, now I don't know who's going to walk through the door".

There were not enough staff to cover all calls if sickness levels were to rise. The local authority Social Services had taken the decision not to place any new people in the care of the agency. The management team at Scott Care had taken similar decision also not to accept any new private clients until the staffing levels and concerns had been satisfactorily dealt with. The manager explained in order to staff to an appropriate level, staff recruitment and induction training was being prioritised in order to provide safe staffing levels. This had been agreed with the local authority as well as private clients. The provider said that staffing levels were determined by the number of people using the service and their care needs, therefore to deliver a service to more people would put people's safety and welfare at risk.

We recommend that the provider seeks advice from a reputable source on staff deployment.

The agency had robust staff recruitment practices, ensuring that staff were suitable to work with people in their own homes. These included checking prospective employees' references, and carrying out Disclosure and Barring Service (DBS) checks before successful recruitment was confirmed. DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people. Employment procedures were carried out in accordance with equal opportunities. Interview records were maintained and showed the process was thorough, and applicants were provided with a job description. Successful applicants were provided with the terms and conditions of employment. All new staff employed are put through the agency induction, to make sure they understand the policies and procedures and vision statement of the service. All staff are also given an

Requires improvement

Is the service safe?

induction training to give them the knowledge, skills and understanding to care for people safely in their own homes. All staff shadow experience staff at the beginning of their employment, and their competency to undertake tasks is observed. This meant that all new staff have had the necessary checks and training to be able to care for people in their own homes safely.

Staff told us that there was a plentiful supply of personal protective equipment (PPE) provided for them such as gloves and they were able to get additional supplies if they needed them. The manager of the service confirmed that team leaders carried additional supplies of PPE and would provide them for staff members as required.

Good

Is the service effective?

Our findings

People told us that they thought the staff were trained and able to meet their care needs. Feedback from people was positive, and relatives comments included, "Staff who call on mum understand her needs, they give her time to do things herself as well.", "I asked staff about the training they have and was pleased to hear the amount of training they do, they certainly understand my dad's needs. People's needs were assessed, with people and their relatives being involved in deciding on the care to be provided. This was documented in the plan of care which was kept in people's homes for staff to read and refer to when necessary.

Staff sought and obtained people's consent before they helped them with any care. One person said "My carer always asks if there is anything else she can do and notices things that I don't". Staff checked with people before starting to assist them with personal care. A staff member told us "I always ask before I do anything, for example I ask for their consent before giving them a shower. People have a right to change their mind and we must respect their decisions. That does not stop us encouraging them to do what is probably best for them".

Some people told us that the staff who call on them at lunch time do warm up a meal in the microwave or make them a sandwich. One person told us she is always asked what she would like to eat and they make her a drink before they leave. A staff member told us "I have to know if people have any food allergies, what they like and what they don't. I would find that information in the care plan". The member of staff also said, ".I will ask people what they would like and sometimes we look in the fridge together". I write in the care plan what the person has chosen, and if they eat the meal while I am there I record how much they have eaten". Staff received training regarding food hygiene during their induction. The manager said we ask staff if they can cook at interview, important as younger carers may not have had the opportunity to learn to cook. Also important to know when rostering staff to work with people needing meals cooked.

Staff completed a range of training to help them to meet the needs of people. We saw and staff confirmed that the induction training provided for care staff included training on basic first aid, catheter care, how to support people with dementia, diversity and equality, food hygiene, health and safety and infection control. The induction course was in line with the nationally recognised 'Skills for Care' common induction standards. The provider is also starting to adapt the induction to make it possible for staff to attain the new Care certificate now being promoted by the' Skills for Care'. These are the standards that people working in adult social care need to meet before they can safely work and provide support for people. Staff were being encouraged to complete a vocational qualification in health and social care. To achieve a vocational qualification, candidates must prove that they have the competence to carry out their job to the required standard. Staff confirmed that they could access additional training if there were particular areas where they felt they needed additional support. This meant that staff were given the skills they needed to provide care for individuals with specific needs, such as Parkinson's and diabetes.

Staff were supported through individual supervision and we saw the yearly appraisals for all staff had taken place. Spot checks of care staff were carried out in people's homes. A spot check is an observation of staff performance carried out at random. These observations were undertaken after consultation with the people they would be caring for. Only if people expressed their agreement to occasional spot checks being carried while they were receiving care and support would their care be observed. People thought it was good to see that the care staff had regular checks, as this gave them confidence that care staff were doing things properly. We saw the records for a spot check and this included punctuality, personal appearance of staff, politeness and consideration of respect for the person and the member of staffs' knowledge and skills. Spot checks were recorded and discussed, so that care staff could learn from any mistakes, and receive encouragement and feedback about their work.

Staff were trained in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). Staff understood the processes to follow if they felt a person's normal freedoms and rights were being significantly restricted. The manager explained that they get a full assessment and care plan from the local authority social services before they visited in most cases. This indicates people's ability to understand their care needs and to consent to their support. When people lacked mental capacity or the ability to sign agreements, a family member or representative signed on their behalf. The manager said they would still carry out their own assessment and this often included the family members and health and social

Good

Is the service effective?

care professionals. They discussed any situations where the agency staff may feel the person could be at risk of harm due to a person's lack of capacity and where decisions may need to be taken in a person best interest.

When carers identified any concerns about people's health they said they would report this to the office. The manager would then inform the next of kin, and contact their GP, community nurse, mental health team or other health professionals depending on the person's medical history and requirement as detailed in their care plan. Staff would always call for an ambulance themselves if the situation warranted it. Each person had a record of their medical history in their care plan file, and details of their health needs. Records showed that the care staff worked closely with health professionals such as district nurses in regards to people's health needs. This included applying skin creams and catheter care. Staff said they would report any changes in a person's mobility as they may need to be reassessed and may need the input of an occupational therapists or physiotherapists. Staff told us that they had been trained to use special equipment such as hoists in people's homes to protect the person they were assisting.

Good

Is the service caring?

Our findings

People and their families we spoke with were satisfied with the quality of care they received and they found staff caring & respectful. People described their regular care staff as very caring and flexible. One person told us "I couldn't wish for better carers" and others said "The staff are very caring and helpful" and "I can't fault the carers, they are such nice girls" One person did have a concern, they told us," they are not as good as they used to be they don't always clear up after they have seen to mum". With their agreement we informed the manager and action was being taken to address this.

People and relatives were aware of having care plans and said they had been involved in their planning. One person said "Yes, I have a care plan and it needs updating as my needs have changed but they are aware of this". Relatives and people who used the service said that staff were good at keeping them informed of any changes needed and involving them when updating their care plan. Staff told us they cared about the people they visited and spent time talking with them while they provided care and support. Staff were made aware of people's likes and dislikes to ensure the support they provided was informed by people's preferences. People told us they were involved in making decisions about their day to day care. One person said, "Staff ask me what I want to wear and what I would like for lunch so they can get it out ready".

Surveys had been returned recently to the agency. Eleven people had submitted their views; these supported what 17 people had told us when we rang people who used the service at random. People said they found the staff to be caring and understanding of their needs, particularly peoples regular carers. However we were also told by a few people that they did not have regular carers, which some people said was unsettling. Everyone we spoke to said that care staff did stay for the full time of the care call. The manager said that the views expressed by people on the questionnaires are used to improve the service they provide and consistency of carers to a priority as more staff are recruited.

Relatives told us that communication with them was good when it related to letting them know about any changes to their relative's health. Some people were informed if care staff were delayed and would be late for a call, or if their regular carer was off sick, and which care staff would replace them. This had not always been the case, one person said, "I need to know who is coming and at what time and this does not happen." We found the manager has been working with the office staff to make sure in future people are fully informed. They are also extending the time the office is open during the day so people will be able to contact the office up to ten o'clock at night. This meant staff would be around to keep people informed of any changes and answer any queries they may have.

Staff had received training in equality and diversity, and how to treat everyone with respect. One care staff said, "I involved people in discussion about what they want to do and give people time to think and make decisions". We reviewed people's care files making sure they covered different age groups and needs. We saw that care plan files included people's information about their social hobbies and interests. They noted if the person had any particular religious beliefs that staff should be aware of while supporting them. Staff knew about people past histories, their preferences and the things they liked and disliked. This enabled them to get to know people and help them more effectively.

Staff were respectful of people's privacy and maintained their dignity. Relatives agreed that the care their relative received from the carers was good and staff treat people with dignity and respect. One relative told us, "Staff look after my mum's privacy whilst they do her personal care and are always very respectful".

The manager did have access to information on advocacy should a person be in need of independent advice and where there is no relative looking out for their interests. The advocate is able to ensure the person's voice is heard regarding the care they wish to receive.

Requires improvement

Is the service responsive?

Our findings

We found that staff were responsive to people's changing needs. One person told us that "I have days when I can do a lot for myself, another day I seize up and need the staff to do most things for me. Staff never mind and are happy to be guided by me". This was not the same for everyone and the manager told us she was aware of the shortfalls around times of calls, and the lack of consistency regarding staff. They were recruiting new staff, and hoped to have groups of staff who will know a number of people in an area; they would then know the person when asked to visit during staff holidays or sickness. By knowing the people they care for staff would know straight away when people are not well and be able to take action.

People's needs and risk assessments were undertaken before the care began. The time of calls was discussed as were the length and the number of visits per day or week. This information was recorded in their care plans. Each visit had clear details in place for exactly what care staff should provide at each visit. This might include care tasks such as washing and dressing, helping people to shower, preparing meals, making drinks, or assisting people with their medicines. Some visits also included domestic tasks such as shopping. The staff did not always know the person they were visiting, at these times staff relied on the care plan and talking to the person to know what their needs were. Some people were not able to communicate effectively so a detailed plan is therefore important to make sure a person's care needs were fully met.

The care plans contained information about people's backgrounds, family life, previous occupation, preferences, hobbies and interests. The plans also included details of people's religious and cultural needs. The staff told us this enabled them to have an understanding of the person they were visiting and were able to engage them in conversation about things of interest to them. One staff said, "This is particularity useful if the person we are caring for has dementia, being able to talk to them about areas of their life they remembered often calms their anxiety. Care plans detailed the care provision that had been agreed and whether one or two care staff were allocated to the person. It also described how they liked things done and order they like thing to be done in. This was particularly helpful for care staff assisting people new to them, particularly if communication is difficult as they have sufficient detail to provide the agreed care the way the person likes it.

The senior staff carried out care reviews with people after the first 28 days of receiving care, and then at six-monthly intervals. This was flexible and a care plan could be reviewed earlier if the persons care needs changed. For example, if a person has a stroke and then needed more assistance with personal care. Any changes were agreed with the person, their relative and Social Services Care Manager if appropriate. The assessments and care plans would then be updated to reflect the changes. The manager told us that the care staff that provided care for the person were informed of any changes.

People told us they would have no hesitation in contacting the manager, or would speak to their care staff if they had any concerns. People we spoke with were not all confident that their complaint would be taken seriously. One person told us, I have complained about all the different staff they send and the poor time keeping but nothing has been done". Other people told us, they did not have a copy of the complaints procedure, and that their complaints did not appear to have been passed on to the manager, or the manager had not done anything to resolve the complaint.

The complaints procedure stated that people would receive an acknowledgement of their complaint within two days, and the agency would seek to investigate and resolve the complaint within 28 days. The provider said that any concerns or complaints were regarded as an opportunity to learn and improve the service, and would always be taken seriously and followed up. We saw complaints that had been recorded and logged when received. A recent complaint had been appropriately investigated and resolved, and the correspondence was on file.

The manager told us they usually visited people in their homes to discuss any issues that they could not easily deal with by phone. They said face to face contact with people was really important to obtain the full details of their concerns.

We also noted that the procedure stated 'if anyone feels that Scott Care Ltd had not dealt with a complaint to their satisfaction, they should complain to the Care Quality Commission which regulates their service'. This is not the

Requires improvement

Is the service responsive?

case the lead agency for investigating complaints which have not been resolved satisfactorily by the agency are the local authority Social Services if they are being funded by them and or the Local Government Ombudsman.

We recommended that the provider seeks advice and guidance from a reputable source about complaints procedure.

There had been missed calls over the preceding months; the manager said that when calls were missed it was treated seriously with social services being informed and a full investigation being undertaken. The manager said that they learnt from this and had put measures in place to stop this happening in the future.

Requires improvement

Is the service well-led?

Our findings

We saw that people's views were regularly sought by the agency in order to improve the quality of the service they provide. The agency sends out questionnaires every quarter alternating the people who are proposed for comments each time. We saw some responses to a questionnaire sent out on the 25th June 2015, People had been asked to give their views about the service. They asked questions such as, 'do staff stay the full length of the call, do staff wear gloves appropriately, do you have regular carers, and are you well cared for'. Not all surveys had been returned by the 1st July 2015, but of the eleven that were submitted, people had completed the form and some had added comments. The manager said that when they have received all the responses these would be analysed and changes made to improve the service. For example they have already identified that people were not having any consistency in the staff that visit them. The manager was recruiting more staff with the intention to have groups of staff working in set areas. The staff would be introduced to all the people being cared for in that area by the manager. This would mean that when one main carer was absent for any reason, the visit would be covered by someone they have already met.

We saw that the vision and values of the service were display on the wall of the office. The mission statement was 'to provide a wide range of cost effective services based on sound principles by competently trained staff committed to improving quality of life'. Staff spoken with were clear about the values of the service and their own personal values. For example, one staff member told us they thought it was important to respect the rights of service users. Another staff member told us that their values centred on caring and respecting the rights of the people they care for".

Staff told us they found the manager easy to approach, and they were happy to discuss problems with them. One member of staff commented "She is always supportive and on hand to help with any issues, anytime". The staff did not feel the same about the office staff, they were not confident that messages were past on. One staff member said "I always inform the office if I am running late, it doesn't mean that they have contacted the people I am visiting, it's embarrassing then when you arrive". This showed that not all staff adhered to the provider's vision and values.

We saw the minutes of the last two staff meetings and these confirmed the topics that had been discussed. These included how staff must record the tasks they do in people's home records fully. There had been discussions about late calls and staff being asked to let the office know if they were going to be late. In this event it may be necessary to arrange another carer to go to the person to provide their care, or at the very least let the person know what is happening. We found this was not always the case.

Calls to office staff had not been audited to ensure calls to people were being responded to appropriately. This meant for example that messages for people when staff were running late were not relayed in a timely manner. When we were in the office we heard two staff say they had forgotten to ring two people back as they had promised, we then heard them apologising for not getting back to them earlier . The manager told us that they were working towards getting a reliable procedure in place to keep people and staff informed of any changes. They said having recognised this; office staff were to receive training in customer relations. Systems were being put in place to monitor and document all the telephone calls that came into the office. Checks would then be made to see these had been actioned appropriately. This showed that they had identified the shortfalls in communication and were taking steps to improve the service they delivered to people.

We saw that there were systems in place to monitor the quality of the service provision however; the system had not been effective. For example we saw that documentation returned to the agency each month from service user's homes was read and dated. Any issues regarding the daily records or medication record sheets were taken up with individual staff members during their supervision. Where things had been missed by a number of staff then the manager said they would deal with that in a staff meeting. For example we saw in the minutes of the last meeting staff were reminded that they must not leave gaps in the daily record as they are contemporaneous and there should be no spaces for more words to be added after the entry has been signed. However there monitoring of documentation had failed to notice that medicines had not been documented correctly. They also missed that not all care plans included exact times of the calls. We found two out of three plans checked in relation to this issue did

Requires improvement

Is the service well-led?

not include exact times for calls, as specified in their service user guide. This meant that the provider had not provided service to people as specified in their commitment to people.

The manager reported that they met regularly with the operational manager for supervision, support and guidance. The manager was working towards objectives that had been agreed with their operational manager. For example, they had been set tasks such as supervising staff and ensuring that back to work interviews had been completed to address concerns relating to staff absence. We noted that this had improved staff morale and service delivery.

The manager was aware of when notifications had to be sent to CQC. These notifications would tell us about any important events that had happened in the service. Notifications had been sent in to tell us about incidents that had happen involving the staff and people using the service. We used this information to monitor the service and to check how any events had been handled. This demonstrated that the manager understood their legal obligations.

The Statement of Purpose for the service was reviewed on 18 June 2015. However, this document references previous regulations and had not been updated to include reference to the fundamental standards that came into force on 1 April 2015. The service user guide references regulations that related to the National Minimum Care Standards (2000). These regulations were superseded by the Health and Social Care Act (2008). This meant staff could not refer to the new regulation to meet people's needs effectively.

The accident reports completed by staff regarding people who use the service and staff. Accidents were appropriately logged and included information such as any steps taken to deal with injuries at the time. The manager said that she does monitor the incidents and accidents to see if they are able to put in measures to prevent them in the future.

The manager and staff were spoken with regarding how emergencies were managed by the service. They told us the steps that they would take, for example, if they were not able to gain entry to a person's property. This included contacting family members and alerting the emergency services if needed. We found there were policies and procedures in place to instruct staff on the course of action they should take for different events. For example there was a policy on lone working and what to do if they find someone on the floor or unconscious.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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.