Empathy Pvt Ltd

Empathy Nursing and Social Care

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

Overall summary

This inspection took place on the 23 and 26 November 2015 and was unannounced.

We carried out an unannounced inspection of this service on 16 February 2015. Three breaches of legal requirements were found. The registered manager had not ensured that people were protected against the risks of unsafe care being provided by unsuitable staff, had not supported staff with adequate training to meet people's needs and had not provided proper care and welfare to people using the service.

After this inspection, the provider wrote to us to say what they would do to meet legal requirements in relation to the breaches.

We undertook this unannounced inspection on 23 and 26 November 2015 to check that the provider had followed their plan, and to confirm whether they had now met legal requirements. We found improvements in some aspects but not all issues had been properly followed up.

Summary of findings

Empathy Nursing and Social Care provides personal care for people living in their own homes. On the day the inspection the registered manager informed us that there were 42 people receiving a service from the agency.

A registered manager was in place. A registered 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.

Since the last inspection we had received information from whistleblowers which had stated that medication was not properly dealt with and that people receiving the service were always dealt with in a polite manner. We followed up these issues at this inspection. We found that people were respectfully dealt with and evidence that people had usually received their medication properly, though improvements were needed to ensure there is always evidence that this has happened.

On this inspection we found breaches of the Health and Social Care Act 2008 Regulated Activities Regulations 2014 with regarding to providing safe care. You can see what action we have told the provided to take on the back of the full version of this report.

People using the service and the relatives we spoke with said they thought the agency ensured that people received safe personal care. Staff were trained in safeguarding (protecting people from abuse) and understood their responsibilities in this area.

Some risk assessments were in need of improvement to help ensure staff understood how to support people safely.

People using the service and relatives we spoke with told us they thought medicines were given safely and on time. Some improvements were needed to evidence that medicines were properly supplied to people.

Some staff had not been safety recruited to ensure they were appropriate to work with the people who used the service.

The registered manager had provided staff with more training to ensure they had the skills and knowledge to be able to meet people's needs though this needed to be expanded to ensure staff had the skills to meet all people's needs.

Staff understood their responsibilities under the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) to allow, as much as possible, people to have an effective choice about how they lived their lives.

People had plenty to eat and drink and everyone told us they thought the food prepared by staff was satisfactory.

People's health care needs had been protected by timely referral to health care professionals when necessary.

People and relatives we spoke with told us they liked the staff and got on well with them, and we were told of examples of staff working with people in a friendly and caring way.

People, or their relatives, were involved in making decisions about their care and support.

Care plans were not fully individual to the people using the service and did not fully cover their health and social care needs.

People and relatives told us they would tell staff or management if they had any concerns and were confident they would be followed up. However, we found evidence that issues had not all been followed up from expressions of concerns made by people and their relatives.

Staff were generally satisfied with how the agency was run by the registered manager.

Management carried out audits and checks to ensure the agency was running properly. However, audits did not include all issues needed to provide a quality service.

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 consistently safe.

People said that they felt safe with staff from the service. Staff knew how to report incidents to the management of the agency but were not of aware of all the safeguarding agencies to report to if abuse occurred. Staff recruitment checks were not always in place to protect people from unsuitable staff.

Medication had usually been supplied to people as prescribed, though systems were not fully in place to prove that people always received their individually prescribed medicines.

People did not all have detailed risk assessments in place to fully protect their safety.

Is the service effective?

Requires improvement

The service was not consistently effective.

Not all staff had received training to effectively meet all the care needs of people.

People's consent to care and treatment was sought in line with legislation and guidance.

People were assisted to eat and drink and told us they thought the food prepared by staff was of a satisfactory standard.

Is the service caring?

Good

The service was caring.

People and their relatives told us that staff were friendly and caring.

People or their relatives told us they had been involved in setting up care plans that reflected people's needs.

Is the service responsive?

Requires improvement

The service was not consistently responsive.

Care had been provided to respond to people's needs when required. However, care plans had not always contained full information on how to respond to people's needs.

Staff had contacted medical services when people needed support and staff had responded properly to accidents.

Is the service well-led?

Requires improvement

The service was not consistently well led.

Summary of findings

People and their relatives told us that management listened and acted on their comments and concerns but we saw evidence whether this was not always the case. Proper communication to people and relatives by the agency had not always taken place.

Staff told us the registered manager provided generally good support to them and had a clear vision of how friendly individual care was to be provided to people to meet their needs.

Systems had not been fully audited or issues identified had not all been followed up when audited, in order to provide a quality service to people.

Empathy Nursing and Social Care

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 & Social Care Act 2008 Regulated Activities Regulations 2014, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection team consisted of one inspector.

We also reviewed information we received since the last inspection, including information we received from the local authority and information received from whistleblowers who had worked for the agency.

We spoke with the registered manager, four people that received personal care from the agency, five relatives and six staff.

We reviewed people's care records. We reviewed other records relating to the care people received. This included the audits on the running of the agency, staff training, staff recruitment records and medicine administration records.

Requires improvement

Is the service safe?

Our findings

At our last inspection of 16 February 2015, the registered person had not ensured people were protected against the risks of receiving care or treatment that was inappropriate or unsafe. This was because not all staff had been checked for their suitability to provide personal care, a number of people had calls that were significantly late to prevent them receiving care at the time they needed, medication records did not always indicate people received their medication safely and staff had a lack of knowledge how to report abuse. This meant we could not evidence that safe care had always been provided.

Following that inspection the provider sent us an action plan stating how they intended to address this issue. At this inspection we found the provider had not fully followed their action plan and this breach in regulation was not fully met.

People's care records showed some risk assessments were completed to protect their safety. These included people at risk of choking, falling, when walking or moving around, and risk assessments to protect people from developing pressure sores. For example, some people had a risk assessments that stated soft food was needed to be provided and fluids that needed to be thickened so that people would not choke. This meant that people received safe help and support when they were eating and drinking.

Equipment to assist people in their day-to-day lives was listed in the care records such as specialist mattresses to prevent pressure sores developing.

However, we found some risk assessments were not detailed. For example, in one person's risk assessment it noted that the person was a risk of having falls, needed help in moving and handling and catheter care. Another person was assessed as having behaviour that challenged staff. However, there were no risk assessments in place to inform staff how help was provided safely.

There was not always evidence that sufficient numbers of staff were available to meet people's needs as a number of people or relatives told us that calls were not always on time. One person said, "Staff rush things because they are so busy. Office staff have to come out sometimes to do the care because they cannot get the carers." A relative said, "They have been really late sometimes." We saw in a care plan a record called ''client quality assurance dated October 2015 where a relative had complained about carers being constantly late for calls. The person stated in the record, "Most morning calls constantly late… over an hour late and [person's name] has been left in bed in soaking wet nightclothes and on top of wet pads. This did not protect a person from the risk of developing pressure sores and safely protecting their health needs.

We looked at daily records for three people. We found a number of occasions where staff had been late for call times. For example, for one person the call time on 19 June 2015 of 12.00 showed that staff had not arrived until 13.10, over an hour late. For the same person on 21 June 2015 the daily record sheet showed that staff did not arrive until 13.50, nearly 2 hours late. For another person the call time on 9 May 2015 of 7.50am showed that staff did not visit until 9.20 am, one and a half hours late. On 10 May 2015, the records showed that staff did not call until 9.10 am, over an hour late. This demonstrated that there were not enough staff to ensure people's support was provided at the agreed times.

We saw that staff recruitment practices did not always prevent unsuitable staff being employed. Staff records showed that before new members of staff were allowed to start work, checks were made with previous employers and with the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions and ensure that staff employed are of good character. These records showed that the necessary documentation for staff was not always in place to demonstrate they were fit to work for the agency.

The agency had not properly checked a person's application form and crosschecked it with the DBS form. This was because the applicant stated on the application form they did not have any criminal convictions. However, the DBS form showed this person had two previous convictions. This showed that the person had not been truthful in the application form. There was no evidence that this had been picked up by the registered manager. We saw another record, the 'risk assessment following the disclosure of criminal conviction for an applicant/ employee ', which asked the question, ''did the applicant disclose past convictions prior to the check being processed?''. This confirmed the person did disclose they had convictions. We found this had not happened and meant that people were potentially put at risk due to unsafe recruitment procedures.

Requires improvement

Is the service safe?

These issues did not fully protect people's safety as checks had not been put into place to ensure unsuitable staff members did not work for the agency. The registered manager said this would be followed up and later contacted us to say that a proper system had now been put in place to prevent these situations occurring again.

The registered manager stated he had delegated the task of checking application forms to the deputy manager. He recognised he had a responsibility to check this had been properly carried out and he would do so in the future. After the inspection he then sent us information stating that the recruitment process had been reviewed and improved as it now requires a number of management staff to check and approve new staff being recruited. He stated this would provide proper security by ensuring that all aspects were thoroughly scrutinised before new staff were employed, and if relevant information not declared was discovered the applicant would not be employed.

These issues were in breach of Regulation 12 of the Health and Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

People who use the service and their relatives told us that they felt safe with staff from the agency. A person using the service told us, “I feel very safe with the staff that come to help me.” Another person said, “Staff help me. There is no question that I am safe with them.”

A relative told us, “My mum gets help from staff who know what they are doing and I know she is safe with them.”

All the staff we spoke with had been trained in safeguarding and understood their responsibilities. Staff were also aware of reporting concerns to other some outside agencies though they were unaware of the local safeguarding authority, which is the agency responsible for protecting people from abuse. The registered manager said she would ensure that staff were aware of all agencies to report abuse to.

The provider’s safeguarding and whistleblowing policies (designed to protect people from abuse) were available to staff. These told staff what to do if they had concerns about the safety or welfare of any of the people who used the service. However, they did not contain the contact details of all relevant agencies where staff could report their concerns to. The registered manager said this issue would be followed up and information would be included.

Policies set out that when a safeguarding incident occurred, management needed to take appropriate action by referring to the local authority, CQC, or the police. This meant that other professionals were alerted if there were concerns about people’s well-being, and the registered manager and provider did not deal with them on their own.

We looked at a staff record. In April 2014, this staff member was accused of physical abuse and this was reported to CQC by the registered manager. However, there was no investigation report available to us on the day of the inspection showing how this was investigated. The registered manager later sent information which indicated this had been properly investigated.

A person told us, “I am reminded to take my medication by staff.” All the people we spoke to said that they received their medicines. One relative said, “Staff are there to encourage taking medication. There have been no problems with this.”

We looked at how medicines were managed in the service and we saw evidence that people had usually received their daily prescribed medicines. However, on some medicines charts we saw there were a small number of unexplained gaps. The registered manager said he would follow these up. He thought this was a recording issue and that people would have been supplied with their medication.

Medicine charts did not record individual medicines, only whether all medicines had prescribed times had been taken. This meant it was more difficult for staff to ascertain whether all prescribed medicines for people were available for them to take. The medication procedure for the agency indicated records of individual medicines needed to be recorded. The registered manager said this would be followed up.

We saw that staff had received training to support people to have their medicines and administer medicines safely. However, where as needed medicines had been supplied there were no protocols in place to specifically indicate when these medicines should be supplied to the person. There was no evidence of signed agreements with GPs to prevent issues such as whether there were contraindications with other medications. This did not completely ensure that people were protected from medicines that were a potential risk to their health.The registered manager said he would follow this up with GPs.

Requires improvement

Is the service effective?

Our findings

People using the service and relatives of them had mixed views about whether they received the care the support they needed. A person told us, “Staff know what they are doing and are well trained.” Another person said, “Staff seem well trained.” Another person said, “It depends on who you get as to whether they know what they are doing. I have to show them sometimes. Not all staff are confident of doing personal care. For example, wiping me properly and some do not know how to deal with my catheter. Some staff do not know how to read instructions, for example, my food list.”

A relative told us, “New staff sometimes have to be told how to wash.” The registered manager said these issues would be followed up to ensure the service was properly provided. Another relative told us, “The regular staff know what they are doing.”

A staff member told us, “I have had a lot of training. If we need more we have only got to ask”. Another staff member told us, “Training is brilliant”, and that she had carried out training in relevant topics. These included protecting people from abuse, medication, moving and handling techniques, protecting people from hazardous substances, dementia, health and safety, infection control and fire procedures. However, there had not been training in relevant issues such as health conditions such as Parkinson's disease. This meant there was a risk that effective care would not be provided to people.

The staff training matrix showed that staff had training in essential issues such as moving and handling, medication, dementia, infection control, health and safety, food hygiene, first aid, protecting people from abuse and challenging behaviour. We saw evidence that staff had been trained in proper moving and handling techniques by an accredited trainer. The registered manager said that new staff would be expected to complete the care certificate induction training, which covered all essential issues and is recognised as providing comprehensive training. A number of staff had also completed other relevant nationally recognised training.

For issues where staff had not been trained, the registered manager stated this would be followed up to expand training for staff to ensure effective care could always be provided. This was to include relevant issues such care for people who have had strokes, Parkinson's disease, stoma care and end of life care. The registered manager stated that for staff who had not been trained in specific issues this was to be organised in the near future. This would mean that staff would be fully supported to be aware of and able to respond effectively to people's needs.

Inexperienced staff undertook an induction which included shadowing experienced staff on care calls for half a day. After this induction they were then put on personal care calls which needed two staff, which meant they had continued support from colleagues to provide suitable care to people. The registered manager recognised shadowing time was a short period of time to prepare staff to providing care and said this would be extended to a number of days in the near future.

New staff received induction training. We saw evidence of this in the carer induction training workbook which covered relevant issues such as safeguarding people from abuse and the prevention of pressure sores.

The staff we talked with said they had supervision and we saw evidence of this in records. However, the staff records we saw showed that the last supervision had taken place up to seven months previously and new staff we spoke with had not received any supervision. This did not provide staff with support to provide effective care to people. The registered manager said this would be followed up to ensure people had regular supervision.

We assessed whether the provider was ensuring that the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS) were being followed. The MCA is a law providing a system of assessment and decision making to protect people who do not have capacity to give consent themselves. The DoLS standards are a law that requires assessment and authorisation if a person lacks mental capacity and needs to have their freedom restricted, in their best interests, to keep them safe.

There was evidence of mental capacity assessments for people that used the service. Staff said that people would be assessed as to their capacity to make decisions, by the management of the service. The staff we spoke with all stressed that it was people's right to make their own choices and they would be helped to do so whatever their

capacity. If needed, this this would then be subject to a best interest assessment. This is where people are unable to make decisions themselves so decisions are put into place on people's behalf to protect their welfare.

Staff told us that they talked with people they supported and asked them for their approval before they supplied care to them which told us that staff sought people's consent before providing personal care to them.

Staff told us that they had training in the Mental Capacity Act 2005 when we asked them. They were aware of how to look at people's capacity to make day-to-day decisions about aspects of their care and treatment.

People's care plans gave information about the person's support needs in relation to eating and drinking. A person told us, ''They (staff) leave me with food and drink if I need it." We saw evidence in care records that staff had left people with food and drink to make sure they were not hungry or thirsty. There was also recorded evidence of a choice of food and drink available to people. Staff members told us that people's choices were respected and they knew what people liked to eat and drink. We also saw evidence of this in people's care plans. For example, one staff member told us that a person liked corned beef with pickle sandwiches and a hot chocolate drink. We also saw that people were encouraged to eat if this was part of their care plan. These were examples of effective care being provided to ensure that people's nutritional needs were promoted.

Everyone said they were able to see a GP when they needed. A relative told us that a staff member had recommended that she contact the district nurse due to their relative having an infection. There was also evidence in care plans that people had seen medical personnel such as community nurses and GPs. Staff described situations where people had been ill and where they contacted the district nurse or GP to arrange a visit for them.

Good

Is the service caring?

Our findings

Everyone we spoke with said staff were friendly and caring. They also told us that they felt that their dignity and privacy had been maintained.

All the people we asked told us that staff listened to them and they felt able to express their views. One person told us, “Staff are friendly and caring.” Another person told us, “Staff provide excellent care. Carers are very good.”

A relative told us, “They are lovely. They are very caring.” Another relative told us, “Carers are friendly and caring.”

This presented as a strong picture that staff were caring in their approach to people and their relatives.

Staff told us that they respected people's privacy and dignity. They said they always knocked on people's doors before entering their house or bedroom. One staff member told us, “I make sure that I fully respect people. It is their home not mine.”

The staff we spoke with understood the importance of ensuring people could make choices about their day to day lives. One staff member told us, “We always ask what people want such as the type of food they want and what clothes they want to wear. It is up to them how they live their lives. They are no different from us. Everyone deserves respect.”

Care plans emphasised that people should have their independence respected. All the staff we spoke to said this was an important part of the personal care supplied to people.

We looked at the ‘carers handbook’. This did not include the agency's philosophy of care which we saw another literature which emphasised that staff should be caring and compassionate, respect people's dignity and promote their independence. The registered manager said this would be followed up and included in the handbook.

People and their relatives told us that that people's care plans had been developed with their or their relative’s involvement. This meant that people had been given the opportunity to agree a plan of care they felt was needed. However, care plans did not include that people or their relatives had signed to agree their care plans to evidence participation in drawing up care plans to meet people's needs. The registered manager said this would be followed up.

The staff we spoke with could describe how they would preserve people’s dignity during personal care such as covering exposed parts of the body when washing people so not all of the body was exposed. This was a good example of a caring attitude.

Requires improvement

Is the service responsive?

Our findings

There were mixed views as to whether staff had provided care at the agreed times that care was needed.

No one expressed any concerns about staff not staying for the full contracted time. However, we saw in records that a number of visits had not been on time. They were either up to 2 hours early or late on a number of records we looked out for June 2015. This meant that people had not received personal care at the assessed times that they needed. It meant that their needs have not been met. For example, having to stay in bed longer, potentially with wet incontinence pads and having the risk of pressure sores developing. Having to wait for food and drink making them hungry and thirsty and not being prompted to take their medication with potential risks to their health.

One person said that he was frustrated about not getting consistent staff to meet his care needs and this meant explaining to a variety of staff how to provide care for him. He said that care staff were sometimes up to two hours late. A relative also said that recently carers had been up to two hours late for some care calls.

However, we saw information in a client quality assurance questionnaire completed in October 2015 that a relative had complained about late calls and ''most morning calls are over an hour late and (person's name) has been left in bed in soaking wet night close and on top of wet pads.'' This was clearly a complaint about the quality of the service but it was not recorded as such. There was no information as to how this situation was followed up with any appropriate action. The registered manager said this would be followed up.

However, one relative told us, "He has trouble with his groin but this is not in the care plan so I have to tell new staff about this.'' This was not an example of responsive care being provided at all times.

These issues are a breach of Regulation 9 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014.

The staff we spoke with were aware of people's preferred routines and needs. Staff informed us that they were instructed to read people's care plans by the management of the service. We saw that care records and risk assessments were reviewed on a regular basis to check that the personal care they received for their changing needs was still relevant..

This meant staff were kept updated and were in a position to respond to people's changing needs.

People had an assessment of their needs and a personal profile in the care plan. This included relevant details such as the support they needed. For example, there was information to encourage people to wear the correct footwear and to place feet flat on the floor to prevent falls. This helped staff to provide care that responded to people's needs.

Some care plans had information as to people's history and background, although not all. We asked a member of staff about a person's family and work history and she said there was no information on the person's file about this. The registered manager said care plans were being reviewed at present and were to include all relevant information to help staff better communicate with people.

A person told us, "They are very good. I get the care I need." A relative told us, "On one occasion carers could not get into the house as my father would not let them in as he was confused. Because they knew it was important that my father got his medication they went back later to try again and he let them in. Staff responded well to the situation." ''

Care plans did not always supply detailed information to meet people's needs. We looked at the care plan of a person that had been assessed as having confusion, associated with people living with dementia. However, the plan did not instruct staff how to manage any behaviour issues or define effective intervention or identify what this behaviour looked like. The registered manager agreed more detail was needed to support staff to deal with these situations. Another person was assessed as having a risk of having falls. However there was no risk assessment in place to help staff managed this situation. This meant that there was a risk that responsive care may not have been provided.

We looked at a care plan for a person from the minority community. There was no information regarding the person's cultural or religious practices. The registered manager said this would be followed up to include this information to ensure the needs of people from diverse cultural communities would be responded to.

Requires improvement

Is the service responsive?

Most people or their relatives told us that management staff had always been responsive to their concerns. A relative told us that the deputy manager had taken her complaint seriously and acted on this when she had complained about the attitude of a staff member. A relative told us that they would speak to office staff if they had any concerns, and felt comfortable about doing so. Another relative told us that if there were any issues then the office staff were good at sorting them out. She said that there were no problems about consistency of staff attending to provide personal care and this responded to her father's needs.

We also saw information from another client quality assurance for in August 2015 which stated that carers did not know how to wash areas of the body properly where the catheter was situated which increased the risk of infection. We spoke to a member of staff who told us that the agency needed to improve follow up action for concerns expressed by people or their relatives. This did not indicate that responsive care was being provided to meet people's needs.

A person told us that office staff had helpfully told her that if she ever had a problem to contact them to sort it out. This had never been necessary but it gave the person confidence that action would be taken as needed.

Staff told us that they would report any complaints to the registered manager or deputy manager and they were confident they would be dealt with speedily and effectively.

The provider's complaints procedure gave information on how people could complain about the service if they wanted to. However this did not include information on which agency to contact should a complaint to the service not be resolved to their satisfaction. The registered manager said this procedure would be altered accordingly.

We looked at the complaints file. Recorded complaints had been investigated and dealt with by the manager and action taken to ensure the issues did not occur again. For example in June 2015 concern have been raised that there was no moving and handling equipment in place. There was evidence that the agency had contacted the relevant agency to obtain an occupational therapy assessment so that proper equipment was in place.

However, staff told us that they had received complaints about people wanting to have the same staff to supply personal care to them. However, this issue had not been recorded as a complaint. The registered manager said any expression of concern would be recorded and treated as a complaint in the future.

A staff member told us that on one occasion a person said they felt unwell. She then contacted the nurse and stayed with a person until the nurse arrived. Another staff member told us that she had rang the person's GP when they had complained of back pain. She had also contacted a district nurse for a person whose leg had bled after falling from a chair. We also saw in records that when people were unwell or had an accident, staff stayed with them until medical services arrived. This told us that people had received care responsive to their needs in these situations.

Requires improvement

Is the service well-led?

Our findings

People or their relatives told us that the agency staff had asked them their opinion of the quality of the service. We saw evidence of this from a quality assurance audit. However, we saw that people or their relatives had complained about a variety of issues through this process but there had been no recorded action to follow up issues raised. For example, there were issues raised by a relative in October 2015 with regard to late calls but no action was indicated as to what had been taken. The registered manager said that this would be this followed.

When we returned for day two of this inspection we were provided with a system to ensure that any issues were followed up appropriately either by further staff training, the staff disciplinary process or other appropriate action.

We saw other quality assurance checks in place. For example, we saw audits of care and medication records. However, there were no action plans in place to deal with any issues raised. For example, there was an issue raised with regard to staff recording their sign out time to indicate whether they stayed the full time of the care call on 7 August 2015 but no action was indicated as to what had been done about this. There was evidence of a medication audit in October 2015 but no action indicated for a small number of sheets where it had not been recorded that medicines were supplied to the person. The registered manager said that these issues would be this followed up to indicate proper action had been taken.

Staff also had periodic spot checks were a number of relevant issues were checked by management such as their manner towards people and their competence in supplying care to people. However, there were again no action plans in place to deal with any issues raised. For example, there was an issue raised with regard to staff arriving late for a care call and not following the care plan on 23 October 2015 but no action was indicated as to what had been taken to follow this up. The registered manager said that this would be this followed up to indicate proper action had been taken.

There were no systems to evaluate important issues such as complaints made and how to prevent their occurrence in the future, and staff recruitment checks.

This did not fully demonstrate that management ensured the service was well led and ensured the provision of high quality care to the people using the service. The registered manager said he would review the quality monitoring system to ensure that all essential systems had been checked to ensure a quality service had been provided to people using the service. This will then help to develop the quality of the service to indicate a fully well led service.

These issues are a breach of Regulation 17 of the Health & Social Care Act 2008 Regulated Activities Regulations 2014. You can see what we have told the provider to do at the end of this report.

There was a mixed response as to whether the service was well led. One person told us, “Office staff are usually good and usually ring us to say if calls are late.” “Another person said, “The office seem ok. If carers are going to be late they ring.” However, one person and three relatives said that office staff did not always inform them of staff being late. One relative said that when staff had changed their roles in what were they were responsible for, she had not been informed of this so it was difficult to know who to contact to sort things out.

Two relatives said that the office organisation was not always good. One relative said on one occasion the agency sent a male carer when the care plan stipulated only female carers should provide personal care. The relative said they had been satisfied with current carers but then, for no reason that they were informed about, staff changed and put on different calls. This had disrupted the continuity of care. These issues do not indicate a well run service.

Staff told us they could approach the registered manager or deputy manager about any concerns they had. One staff said, “We get good support. Management try to sort things out”. They told us that the management expected people to be treated with dignity and respect. Staff thought they were given clear guidance on maintaining personalised care for people.

Staff had generally positive views about the leadership of the agency under the management and the values of the agency, although one staff thought that staff should receive more praise for the good work they carried out.

Staff said that essential information about people’s needs had always been communicated to them and they were expected to read care plans so that they could meet people's needs. These are examples of a well led service.

Requires improvement

Is the service well-led?

Staff were supported through individual supervision and regular staff meetings. Records showed that issues about staff practice were discussed in staff meetings. Staff supervision records evidenced that supervisions covered relevant issues such as people's performance and their training needs. However, regular supervision had not been provided recently as evidenced from the staffing records we saw. The registered manager said that this would be this followed up to ensure people were provided with this support.

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.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **People had not been protected from risks to their safety.**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **People did not always receive care that responded to their needs.**

This section is primarily information for the provider

Enforcement actions

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The service did not properly check and act on the quality of care supplied to people.