121 Care & Mobility Ltd

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

Summary of findings

Overall summary

121 Care and Mobility provide care and support to people in their own homes. The service is provided to mainly older people and some younger adults. At the time of the inspection the service was providing up to 5000 visits per week to people who needed domestic calls and or visits to help with personal care support. At the time of inspection approximately 375 people were receiving support with their personal care. The service provides care and support visits to people in Whitstable, Herne Bay, Faversham and surrounding areas.

The service is run by an experienced registered manager. 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 2008 and associated Regulations about how the service is run.

Risks associated with people's care and support had been identified, but there was not always sufficient guidance in place for staff, to aid risk management and help ensure people were safe.

Comprehensive audits and systems in place to monitor that the service ran efficiently had not been utilised effectively and had not picked up that although most people found the office staff kind and courteous, they did not always tell people about changes to their calls or ring back when messages were left. Care staff also felt communication from the office could be improved upon, and supervisions had not picked up or addressed staff feelings of being unsupported. Audits of care records had not identified where there were gaps in risk information. People had opportunities to provide feedback about the service provided, but they did not in turn receive feedback about how their comments were used to help service development.

People told us they received their medicines when they should and felt their medicines were handled safely. They said that they felt safe using the service and when staff were in their homes.

The service had safeguarding procedures in place and staff had received training in these. Staff demonstrated an understanding of what constituted abuse and how to report any concerns in order to keep people safe.

People had their needs met by sufficient numbers of staff. Most people told us staff generally arrived on time and that on the whole they received support from a team of regular staff. New staff underwent an induction programme, which included relevant training and shadowing of experienced staff, until they were competent to work on their own.

People told us staff always asked for their consent before carrying out activities at each visit. People were supported to make their own decisions and choices although some were supported by relatives. The Mental Capacity Act (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest

decision is made involving people who know the person well and other professionals, where relevant. The registered manager understood this process and was working to the principles of the MCA.

People were supported to maintain good health and they told us staff were observant in spotting any concerns with their health and taking appropriate action.

People were involved in the initial assessment and the planning of their care and support and some had chosen to involve their relatives as well. Care plans reflected the care and support people received. People told us their independence was encouraged wherever possible.

People felt the majority of staff were kind and caring. People said they were comfortable with staff in their home and undertaking their personal care they said staff listened and acted on what they said. People were treated with respect and their dignity and privacy protected. People said they felt able to raise concerns if they had them.

The providers had invested in the expansion of the service and were proactive in participating in pilot projects with other stakeholders regarding the most effective delivery of domiciliary care currently and in the future. The office was well equipped to enable the smooth running of the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we have asked the provider to take at the end of this 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.

Risks associated with people's care had not always been identified or sufficient guidance provided to staff about how to keep people safe.

Medicines were managed appropriately. The recruitment procedure ensured checks on prospective staff suitability were conducted in accordance with legislation.

People's needs were met by sufficient numbers of staff and these were kept under review.

Is the service effective?

Good

The service was effective.

People's care and support was delivered by staff whose knowledge and training was up to date, to ensure it was effective.

People were able to make their own decisions and staff offered choices appropriately.

People's health needs were met and staff were observant in spotting concerns and took appropriate action.

Is the service caring?

Good

The service was caring.

People were treated with dignity and respect. Staff were caring and friendly towards people.

People were encouraged and supported to maintain their independence where possible.

Staff took the time to listen and interact with people so that they received the care and support they needed.

Is the service responsive?

Good

The service was responsive.

People's care plans reflected the care and support they received and included their wishes and preferences.

People had opportunities to feedback their views on the service provided and an action plan was devised to inform service development.

Most people were not socially isolated and had support networks in place.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

Audits and systems were in place to monitor the quality of care people received but these had not always been effective in identifying shortfalls in people's care.

People felt that office staff were pleasant and courteous but not always effective in responding to calls or messages or telling them about changes. Staff thought communication from the office could be improved upon.

The registered manager did not have oversight of all the issues of the service. this impacted on the quality of service provided.

121 Care & Mobility Limited

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 inspection took place on 21, 22, February and was announced with 48 hours' notice, on the 1st and 2nd March we telephoned people using the service and a sample of staff to gain their views about the service. The inspection was carried out by one inspector. This was the first inspection since the service had moved and registered at the new offices in FDS House, Reeves Way, in Whitstable.

The provider had previously completed a Provider Information Return (PIR) under their old registration but had not yet been requested to complete an updated version. 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. Prior to the inspection we reviewed this and other information we held about the service, including safeguarding incidents, whistleblowing and we looked at any notifications received by the Care Quality Commission. A notification is information about important events, which the provider is required to tell us about by law.

During the inspection we reviewed people's records and a variety of documents. These included seven people's care plans and risk assessments, five staff recruitment files, staff training, supervision and appraisal records, visit and rota schedules, medicine and quality assurance records.

We spoke with 24 people who were using the service, three of which we visited in their own homes, we spoke with four relatives, the registered manager, the assistant manager, company director, 11 care assistants and three members of the office staff.

Following the inspection we received feedback from two social care professionals who have had contact with the service.

Requires Improvement

Is the service safe?

Our findings

Most people and relatives told us they felt safe when staff were in their homes and when they provided care and support. Comments included, "I usually have the same people and they usually come around the same time." "Usually have the same people but recently had a chap it made a nice change." "They come out and do everything I want and more." "It varies on times or sometimes staff are delayed and the office call you."

Risks associated with people's care and support had mostly been identified. For example, risks in relation to people's environment, memory, behaviour, communication, falls, pain, skin condition and pressure areas, loss of confidence and moving and handling needs. People told us that they felt risks associated with their care and support were managed safely. Staff were provided with 'other conditions' training that provided them with a basic understanding of some of the more common conditions they deal with for example epilepsy and diabetes.

Out of the seven care plans we viewed there were a few examples where needs and risk assessments did not always show the actions staff should take to reduce risks. For example in one case a person with epilepsy was having a bath call, no reference had been made to the risk to the person in the event that they suffered a seizure whilst bathing. There was no information to inform staff what the persons seizure might look like and how long it might last and what they may be like post seizure to ensure staff responses ensured the person was kept safe for example, empty the bath, cover the person until they recovered, call and ambulance if they remain unresponsive for a length of time.

In a second example a person was at risk of pressure ulcers, they had been provided with an air mattress to help reduce the risk but the risk assessment and care plan made no reference to the setting the mattress should be at to make the risk reduction effective nor whose responsibility it was to check the mattress setting and what staff should do if it was wrong. In a third care plan the person was diabetic and they were supported by their partner who was present for the majority of the time, however in the care plan and risk information staff were told to inform the husband if the person was having a 'Hypo', but what this might look like for the person was not explained in the care plan or risk information and in the absence of the partner care staff may not understand the person was experiencing low blood sugar Hypoglycaemia which can lead to serious complications for people including losing consciousness and staff had no information to hand of what action they should take.

The provider had not fully mitigated the risks to people's health and safety. This is a breach of Regulation 12 (2) (a) of the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

People had their needs met by sufficient numbers of staff. Most staff felt there was sufficient staff to meet people's needs on the whole. The registered manager kept staffing numbers under review and told us that the service had an on-going recruitment programme in place and turnover of staff was not high.

Feedback from people provided a mixed picture as to whether there was good continuity in the staff that supported them, some said they experienced regular changes which was unsettling. We asked the provider

for information about how many people who received the regulated activity of personal care had a regular main carer. We were informed that approximately 80% of people had at least one main carer within the team that supported them. Most people told us that staff "more or less" arrived on time when they were expected barring emergencies. A computerised system allowed office staff to interrogate information relating to early and late calls and they informed us that approximately 8% of calls fell into these categories. Office staff responsible for checking timesheets called care staff into the office if issues were identified affecting the times of calls they were making on their rota but the effectiveness of this process remains an area for improvement. Most people said they were always informed if staff were running late but this was not everyone's experience. Staff told us they generally worked in a geographical area, and whilst there was not any travelling time included in the calls rota for each staff member there was a tolerance of half hour either side of the given call time; most people told us staff arrived within this time.

On occasion due to human or computer error some calls had been missed 19 were recorded in a six month period from September 2016 to the date of inspection. To address this the service had implemented a system of call monitoring to staff who fail to sign into calls using their Personal Identification Number (PIN), this was helping to ensure staff had visited all the calls they had been scheduled for.

Most staff felt they were able to reach the calls on their schedules if they were not called upon to do anything that might take them outside their usual area or if they needed to support someone for longer at a call. The majority of people said staff "usually" stayed the full time or did all the tasks required and a number said staff always asked if there was anything else they could do for them.

There was good coverage by the office which was open seven days per week and provided cover for calls between 7 am and 10 pm at night, outside of these hours a member of staff is available to take emergency calls. The majority of people said they could get someone on the phone if they needed. The registered manager and senior staff could also be contacted by office staff if there was an emergency that office staff could not handle.

People told us they felt they received their medicines when they should and staff handled them safely. There was medicines policy updated in 2015 and a medicines management procedure in place. Staff had received training in the management of medicines. It was policy that staff only administered medicines from original packaging or a pharmacy prepared dossette box (a monitored dosage system). Newly trained staff shadowed experienced carers and were in turn shadowed for their initial medicines administration; their competency was checked by senior staff. Staff administering medicines completed Medication Administration Record (MAR) charts which were audited for completion.

The registered provider had informal arrangements in place in the event of bad weather that ensured planned staff undertook walking calls in the area near to their home to avoid the necessity of driving. Calls to people living on their own, or who required medicines or food and fluids were prioritised. Staff were asked about their availability in the event of bad weather.. Directors and the registered manager had 4x4 vehicles which could be used to access more remote calls if needed. To date the present system had worked well but we have discussed with the registered manager the need to formalise these plans into a clear strategy, and this is an area for improvement.

We looked at five recruitment files of staff that had been recruited within the last 18 months, all checks were in place but we noted that employment history checks for some staff only went back as far as the last ten years of employment. The registered manager was unclear why the application form had been changed to this and made immediate changes to ensure a full history was gathered from all current and prospective staff as required by legislation.

People were protected from harm or abuse by staff. There was a clear safeguarding policy in place and staff were emailed when a change occurred so they could read the changes made. Staff had received training in safeguarding adults; they were able to describe different types of abuse and knew the procedures in place to report any suspicions or allegations. Staff were encouraged to report abuse but some said they did not always get feedback on the action the service had taken. We have highlighted elsewhere in the report the improvements needed in communication and feedback to staff.

Good

Is the service effective?

Our findings

The majority of those people and relatives we spoke with were generally satisfied with the care and support provided by the agency. Comments included: "I am supported very well, they help with my personal care in the morning they are lovely girls". "I am very happy with the service I am getting. "They will do other things for me like put out the recycling and the rubbish, I cannot fault them at all a very nice company." "It's as good as it's gonna be but I would not want it changed as mum would be unhappy." "They try to get me into bed by 8:30 pm because they know I prefer it, they seem to be good at the moment and I can do a lot more for myself now I can't suggest any improvements." "If I want anything else they are only too happy to do it for you."

People were asked to sign their care plans and risk assessments as a sign of their consent and they said that staff always asked them what they wanted when they offered support. Staff were trained in the Mental Capacity Act (MCA) 2005. The registered manager told us that no one was subject to an order of the Court of Protection, one person had a Power of Attorney in place for their finances but no one else had Lasting Power of Attorney arrangements. 21 people were subject to Do Not Attempt Resuscitation (DNAR) orders and this information was logged so that staff ringing in to report someone unwell would be able to inform ambulance staff if necessary.

The Mental Capacity Act 2005 (MCA) provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant. In discussions the registered manager demonstrated they understood the process that would be followed and gave a recent example where a best interest discussion had taken place with a health professional regarding the safe moving and handling of a person using the service.

Most people and relatives felt staff had the right skills and knowledge to provide care and support that met people's needs. One person commented, "They are very good with X, she responds to them and everyone has been very helpful". Another person said, "They are gentle when working with me, it's difficult when they are hoisting me but they are doing their best". Most people said they were happy with the quality of the care they received and would report this if they were not.

Staff understood their roles and responsibilities. Staff had completed an induction programme, which included shadowing experienced staff, attending training courses and completing knowledge tests; staff also received a staff handbook. The induction was based on the Skills for Care Certificate. These are an identified set of 15 standards that social care workers complete during their induction and adhere to in their daily working life. The registered manager had a programme in place to ensure that all new staff, irrespective of their experience had training to meet this specification.

Staff attended accredited training courses relevant to their role. These were provided by a training provider and covered all the mandatory courses for example food safety, infection control, fire safety, first aid, moving and handling, health and safety, safeguarding and medicines management all of which were

updated at specific intervals. In addition staff completed mental capacity and other conditions training which covered for example awareness of dementia, Parkinson's, and diabetes. Staff said the training equipped them to undertake their role and they were enthusiastic about developing their knowledge of some areas and would like the updated trainng they undertake to be adjusted to take account of the knowledge and experience they have already gained in their work. Staff have shared these views with the management team to help direct training and make it more effective.

There were lots of opportunities for office based staff for career progression and to achieve higher qualifications with four staff within the office undertaking Diploma in Health and Social Care (formerly National Vocational Qualification (NVQ) at level 5 and a further four in progress (Diplomas are work based awards that are achieved through assessment and training). To achieve a Diploma, candidates must prove that they have the ability and competence to carry out their job to the required standard. Staff felt the training they received was adequate for their role and enabled them to meet people's needs.

Care staff were provided with opportunities to complete a Diploma in Health and Social Care at level 2 or above relevant to their role. The registered manager informed us that 39 staff had completed their level 2, 26 staff had completed their level 3, 20 were in the process of completing this qualification and further three staff were signed up to undertake Level 3 training.

Staff had opportunities for supervision and unannounced spot checks of their practice, spot checks were undertaken by senior staff, whilst staff were undertaking visits to people. During these observations how individual staff delivered support was checked against good practice around communication, offering choices, privacy and dignity, moving and handling and encouraging independence. Staff received an annual appraisal and they told us they had had opportunities to discuss their learning and development. Team meetings were held where staff were able to discuss any issues or be kept informed of learning from complaints or safeguarding events and were reminded about changes in policies and procedures and the need to ensure their practice was in line with these.

People's needs in relation to support with eating and drinking had been assessed and were recorded and this was checked by supervisors undertaking care and quality checks at people's homes. Most people required minimal support with their meals and drinks. People who received support with meals said that they were happy with the meals staff provided and were offered choices. Staff told us where people were at risk of poor hydration, measures were in place to reduce these risks, such as leaving drinks and snacks within reach for them to have later. Staff usually prepared a meal or snack from what people had in their home. Special diets were supported including diabetes.

People were supported to maintain good health. People and relatives told us staff were observant in spotting any concerns with people's health and took any appropriate action when they were concerned. One relative said, "X had a chest infection and with our permission 121 staff arranged for a GP visit." The provider had developed factsheets relating to conditions staff were most likely to come across to help ensure people remain healthy, including warfarin awareness, continence awareness, anaphylaxis, angina and heart attacks, staff could ask for these if they felt they needed more information.

Staff talked about when they had come across situations when people had been unwell. One staff member had telephoned 111 with the consent of the person, another person told us that a GP had been called and an ambulance on behalf of their partner who was admitted to hospital. Staff said if they found someone unwell they always rang the office to inform them and consent was sought to ring the GP or other medical support where appropriate and family members were informed. People sometimes refused despite attempts to encourage them to agree to a referral being made, refusals were recorded and information

usually passed onto the funding authority care manager.

Good

Is the service caring?

Our findings

A staff member told us that the vision of the service was to 'encourage independence and enable people to continue to live in their own homes.' People told us that staff encouraged them to do things for themselves and retain their independence. Comments included: "They used to help with my personal care but now the main thing they do is help me with getting to the shop and doing my weekly shopping they also help me with some domestic tasks." Another said they had previously been on four calls per day following discharge from hospital but since then they had gradually taken more control back of their life and now staff called once per day to provide a shower call.

People and relatives told us staff were kind, caring and helpful most felt staff listened to them and acted on what they said. People were relaxed in the company of staff and they and relatives were complimentary about the staff. Comments included, "Their attitudes are pleasant and lovely." "They are always respectful." "They are lovely girls." "There are some I like more than others." "They are apologetic if late, always friendly and polite I cannot fault them at all." "They provide very good care to me." "They have got better recently around times but I can't fault the girls".

One social care professional told us that they had not received any quality issues about the service since the service had taken on more people from a closing service. People who received personal care said they felt comfortable with staff who respected their privacy and dignity. One person did say they wished staff would say goodbye to them when they were going which was often not the case and this made them cross, we have passed this to the agency for this to be made clear to staff in future.

People and relatives felt staff observed peoples dignity and privacy when in their homes and treated them with respect and they trusted that staff did not speak about them outside of their home .The service user guide which is a booklet people receive at the start of their service so they know what to expect from the service assures them that information about them will be treated confidentially. Carers are reminded regularly in their weekly 'Carers newsletter' about the use of social media and maintaining confidentiality.

We observed a member of staff undertaking a visit to a person; we saw there was affection and a good rapport between the person being supported and the staff member with the staff member demonstrating a patient and caring approach.

People told us they received person centred care that was individual to them. People felt staff understood their specific needs relating to their age and physical disabilities. Where there was continuity of staff or a lead carer involved the staff concerned had built up relationships with people and were familiar with their life histories and preferences. Care plans contained some details of people's preferences, such as their preferred name and some information about their personal histories.

In discussion staff demonstrated a loyalty to the people they supported, they cared what happened to them and spoke about them in a meaningful way. During review visits and unannounced spot checks of staff practice people were asked if they were happy with the standard of support that staff delivered to them.

The registered manager told us at the time of the inspection that only one person required support to help them with decisions about their finances. The majority of people who may need support with decisions in regard to their care and support were supported by their families or their care manager, and no one had needed to access any advocacy services. The registered manager was aware of advocacy services and would seek support for anyone who was self-funding without the network of family of care management support.

Good

Is the service responsive?

Our findings

People told us they were involved in the initial assessment of their care and support needs and in planning their care. Some people told us their relatives had been involved in these discussions. Assessments were undertaken by senior staff. The majority of care packages were funded by the local authority with only a small amount of privately funded care. Following referral to the service people were visited and assessed. The registered manager told us that sometimes if urgent referrals were made assessment of the person may happen at the same time of the first call to ensure they met a two hour deadline required by the local authority. Following assessment, office care co-ordinators usually rang the person to explain the service and an agreed time for visits. Co-ordinators matched staff to cover the visits and this process was usually based on gaps within staff schedules, staff working in the geographical area, people's preferences and staff skills and experience.

Assessments of people's needs included areas, such as whether the person had mental capacity to make decisions for themselves, a checklist of health conditions, how their medication is managed, whether they have a life line and attend a day centre, a medication assessment, a care and personal needs assessment, any risks they may be subject to around, memory, behaviour, falls, communication, comprehension, moving and handling. A record of any equipment they used for their support and when this was last serviced. What support they required around meal preparation, their nutritional likes and dislikes, continence management, cognition, and a risk assessment of their home environment.

When completed assessments formed the care plan and additional detail was added as staff got to know more about people's preferences and needs, this included what they could do for themselves and what help they needed from staff. Care plans were person centred and contained information about people's wishes and preferences in relation to their personal care. Most care plans viewed were well completed with lots of additional detail regarding people's personal care routines and the support they required, they did vary in detail depending on who had completed them. People told us senior staff came out to review their care plans usually annually but this could be sooner if things had changed.

People had irritations and grumbles about the service they received but these were more about communication issues and call times rather than the quality of the service they actually received from staff; we have addressed some of these issues elsewhere in the report. Most people were satisfied with the support they personally received and felt this reflected their preferences and wishes.

Most people we spoke with were not socially isolated and had good family support from family or visitors; some were able to get out and about in the community, go shopping or attend groups, clubs and/or church. They were sometimes supported to do this by staff. Some people although they had access to telephones to contact people and a television to keep them informed of local, national and international events they were at risk of social isolation because they lived alone, some were unable to go out or do anything for themselves and their relatives lived some distance away. They were therefore reliant on the visits made by staff each day which they looked forward to.

Discussions with people showed that when they were not happy with a particular staff member there had been no problem with changing to another staff member. When people did not want a particular care worker this was recorded on the computer system, which blocked them from being scheduled to undertake visits to that person. Most people said they usually knew who was coming but this was not always the case for some people who had experienced continuous change in the staff who visited them before it settled down. People could receive a schedule of their visits in advance if they requested this.

Everyone we spoke with was very clear that if they were unhappy with the service they received at any point they would have no hesitation in making a complaint to the office, some people had complained previously and the service had responded well but sometimes issues about late calls recurred and this was a frustration. The complaints procedure was contained within information in people's care folders, which were located within their home along with their care plan. Records showed there had been eight complaints since the service was re-registered in April 2016 all were now closed. The registered manager told us that one complaint had been used as an anonymised case study at a registered provider forum and learning from all complaints was used as a driver to improvements.

People had opportunities to provide feedback about the service provided. People were visited by senior staff as part of staff's observational supervisions and had the opportunity to raise any concerns during these visits. In addition when people received a care plan review visit they were asked for their feedback about the service they received and also received telephone calls to check how things were going. The provider sent out questionnaires at the end of 2016, to gain people's feedback about the service and an action plan was put in place to address any areas for improvement, people were not given feedback about the outcome of the survey and we have addressed this elsewhere in the report.

Requires Improvement

Is the service well-led?

Our findings

The majority of people we spoke with stated that they were mostly satisfied with their support, but about 20% of people expressed concerns. About 30% of staff spoken with also said they were unhappy and were thinking of leaving their job; some of their reasons were around how the service was managed.

A professional told us that from their perspective the service had worked well with the local authority in transitioning people from a closing service over to the 121 service, people who had transferred from that service and staff also expressed satisfaction with 121.We noted written praise about the service from the local authority for its planning for and smooth handling of the transfer of staff and people over to 121. We noted many compliments received from satisfied relatives regarding the care delivered by the service to their family member.

There was an established registered manager in post. They worked three days per week and was supported by an assistant manager who worked Monday to Friday and was training to take on the registered manager role. A team of coordinators assessors and supervisors undertook the initial assessments, care plan reviews, quality assurance visits and staff supervision as well as coordinating visits to people.

There were a range of audits, checks and systems in place to ensure the smooth running of the service, but these had not been effective in highlighting and addressing some of the issues we have highlighted. Staff understood their role and responsibilities and there was an effective system to monitor that staff received training, spot checks, supervision and appraisals, but this had not picked up that a number of staff were not happy in their role and did not feel well supported.

We have identified failings in communication between the office and people using the service and also care staff, breaches of confidentiality at office level. Audits that reviewed care plan content had failed to identify risks for some people. Quality monitoring is an area that we have identified as requiring improvement so that action can be taken in a timely way to ensure compliance. This is a breach of Regulation 17 (1) (2) (a) (c) (d) (e) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Communication from the office was an unresolved issue even for those people and staff mostly happy with their service. People described office staff as pleasant and kind when they spoke with them but many said they were often not told about changes to their times or carers. When they rang the office and left messages staff rarely rang them back. The registered manager was unaware of some of the issues people had raised with us and this made her aware of how with the expansion of the service her role had changed and removed her from the direct day to day working of the service; she said she was determined to address this. For example someone told us that following a breakage at home which they were unable to clear up themselves they telephoned the office for help as they were not due a further visit that day. They said they were told that everyone was on a break and they could not help. The registered manager was very disappointed in the response the person had received and said they would always try to help out if they could or alert someone on behalf of the person.

Care staff also commented that at times communication with them from the office was poor and there was a lack of feedback from co-ordinators when messages were left. The service operated a system whereby each co-ordinator has a message book, all messages for them should be recorded in these books so they can work their way through messages when they returned to their desk or were free; feedback showed this arrangement was not working well. For example we rang a carer as part of this inspection they told us they had spoken with the office at 10:25 am that morning and left a message for their co-ordinator to ring them, we spoke with them at 15:00 hours and they were still awaiting a call back.

Another member of staff told us they had now reported a safeguarding issue twice because they had received no feedback from office staff as to what action had been taken the first time. We learned that action had in fact been taken but the member of staff had not been kept informed.

Staff had opportunities to express their views through team meetings, supervisions, and a suggestion box and more recently a staff survey but some staff spoke about poor attitudes amongst both office staff and other carers not being dealt with effectively even when raised.

Carers raised a range of concerns that we have fed back to the registered manager including several expressions of concern about lack of confidentiality within the office and amongst carers. One carer said they were in the office when they heard office staff discussing whether another carer who had telephoned in sick was genuinely unwell, in another instance a carer had told a person supported about why a member of staff was absent.

Some staff felt that there had been ineffective management of some inter staff issues and that the attitudes of some office staff towards carers had not been adequately addressed.

There had been a recent Data protection breach which the service had taken swift action to address. They had worked with some of their partner agencies to resolve the issue and staff had been reminded about the use of social media and this was now discussed at all staff meetings.

Surveys of people using the service were undertaken and their feedback analysed and action plans developed from this. People who said they had completed surveys in the past said they had never received feedback regarding wither specific comments they had made or learned how theirs and other peoples comments were helping to shape the development of the service: this is an area for improvement.

Staff felt there was a lack of praise for those staff who just got on with the job, there was no longer an employee of the month and they felt there ought to be recognition for the good work staff did "a bit more praise would be good" which they felt was lacking in the supervisions and team meetings that they experienced. Team meetings were recorded but varied in depth of content and inclusiveness of staff and we shared our observations with the registered manager to try and implement a consistent and inclusive meeting model to help engage better with staff.

Several staff told us that the service had been very supportive and made adjustments for them when they were experiencing personal problems; we noted that the providers had ensured that back sufferers in the office were provided with appropriate furniture for their needs to meet health and safety responsibilities.

There is a clear management structure; investment had taken place to provide new accommodation and additional office support to meet the demands of an expanding service. A three year business plan was in place to address development and the changing market of domiciliary care. There are regular meetings with stakeholders and the service has been involved in a number of pilot projects with health and social services

to look at ways in which people's needs can be supported more effectively. The service is forward thinking and proactive and they are at the forefront of understanding the landscape for the future provision of domiciliary care but state their focus will remain quality and not finance.

The service had signed up to the Social Care Commitment. The Social Care Commitment is the adult social care sector's promise to provide people who need care and support with high quality services. It is a Department of Health initiative that has been developed by the sector, so it is fit for purpose and makes a real difference to those who sign up. Made up of seven statements, with associated 'I will' tasks that address the minimum standards required when working in care, the commitment aims to both increase public confidence in the care sector and raise workforce quality in adult social care.

The provider was a member of the United Kingdom of Home Care Association. The management team also attended forums and meetings with the local authority and the wider health and social care field. This all helped in order to share good practice and keep up to date with changes.

There had been no accidents or incidents since registration, but processes were in place to ensure these would be monitored and analysed to see if any learning could be taken from them and used to reduce the risk of further occurrences.

Staff had access to policies and procedures via the office or their staff handbook they were also able to log into a staff portal where they could refer to policies and procedures if necessary. These were reviewed and kept up to date. Records were stored securely and there were minutes of meetings held so that staff would be aware of up to date issues within the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People were at risk because the service was not assessing some health related risks and ensuring measures to keep people safe were in place.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Audit systems were not utilised effectively to identify and respond to shortfalls identified by people and staff.