Browncross Healthcare Limited

Browncross Healthcare Limited (Domiciliary Services)

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?	**Requires improvement**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Requires improvement**

Overall summary

This inspection took place on 27 and 28 August 2015 and was announced. We gave the provider 48 hours' notice of the inspection because the service is a domiciliary agency and we needed to be sure that someone would be available. The provider met the regulations we inspected at their last inspection which took place on 12 June 2014.

Browncross Healthcare Limited provides a domiciliary care service to people in their own homes. At the time of the inspection 80 people were using the service. The service had a registered manager 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 2008 and associated Regulations about how the service is run.

Summary of findings

Staff had received safeguarding training and could identify types of abuse. Whilst the service had in place safeguarding procedures to protect people, people who used the service were not always protected from the potential risk of abuse and improper treatment as the safeguarding procedures were not consistently followed.

Medicines procedures were in place, however these were not sufficiently robust to protect the wellbeing of people in relation to PRN (as required) medicines and the medicines policy.

Risks to people were assessed including risks associated with moving and handling, health and personal care, falls and home environment. There were policies in place on how to deal with a range of emergencies and staff had used these procedures to keep people safe. There were sufficient numbers of staff to meet people's needs. Staffing levels were assessed and monitored on an ongoing basis through regular contact with people. Staffing levels were flexible and allocated based on individual needs.

Care workers were knowledgeable about the code of conduct policy and treating people equally. All staff were vetted prior to commencing work. Criminal record checks were made on all staffand essential recruitment documents and records were sought and in place.

The provider's practice was not always consistent in accordance with the principles of the Mental Capacity Act 2005 in order to protect the rights of people.

People who used the service expressed mixed views about the quality of care they received. People overall were very happy with their regular care staff, but less so of replacement staff, whom they found were not as knowledgeable or skilled. Staff received core induction, mandatory training and updates. Field supervisors and care managers assessed the knowledge and skills of care staff and observed their practice whilst on duty. Staff received supervision and annual appraisals.

People were supported to meet their nutrition and hydration, maintain good health, and have access to ongoing healthcare support. The provider kept records of regular contact with professionals.

People who used the service and their relatives told us that staff were kind and caring. Most spoke highly of the regular care staff and said they were treated with dignity and respect. However a number of other people or their relatives said they experienced a lack of responsiveness from office and care staff when care was much later than the scheduled time, which had an impact on them.

People were asked about their needs, care preferences, such as preferred times of care before and during their service to make sure the agreed times still suited their needs. Staff understood about people's needs in relation to their cultural and religious beliefs and respected these.

Care plans were developed in consultation with people and their relatives. But not all were signed by people or their representatives to show they agreed with their plans and that they reflected discussions about how people wished to be supported.

Staff were familiar with peoples' needs, however people's needs were not always clearly stated in their care plans, including their preferences, how best to support them and care arrangements with family members. This increased the risk of people not receiving adequate support to meet their needs and wishes.

People who used the service and their relatives expressed mixed feedback about the care staff's punctuality. Some were very happy and said that care staff were never late. Others said calls could be very late (over the agency's 30 minute allowance) or missed altogether. This had a negative impact on those for whom care was late or missed. Some stated there was a noticeable difference in the knowledge and care provided by new or replacement workers. People were who used the 'reablement' part of the service made good progress in their rehabilitation towards independence at home, for example, after hospital discharge. This was by using the short term care service provided by the agency.

People were advised about the complaints procedure and knew how to complain. However there were mixed views about the provider's handling of complaints.

The provider had failed to inform the Care Quality Commission of relevant notifiable incidents or events that affected the safety and welfare of people. Regulations require that these incidents must be reported.

Staff spoke highly of the management and said they were available whenever they needed and that they received good support.

Summary of findings

The majority of comments in records from home visits, monitoring calls and the latest annual survey showed that people were satisfied with their care. However we were concerned about the extent of mixed experiences expressed to us verbally and feedback from people and their relatives about their care, the organisation and management of the service. The provider used a number of ways to monitor the quality of care.

However, whilst the provider had systems in place to monitor the quality of service, the systems and audits were not sufficiently robust. They had not highlighted the concerns we found during our inspection.

The provider had not identified that the lack of effective quality monitoring systems increased the risk of the service not being run effectively and of areas requiring improvement not being identified and addressed.

We identified seven breaches of regulations. You can see what action we have told the provider to take at the back of this report.

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?

The service was not always safe. Staff had received safeguarding training and could identify types of abuse. However the service users were not protected from the potential risk of abuse and improper treatment as the provider did not consistently follow adequate safeguarding procedures.

Procedures around PRN (as required) medicines were not clear, which increased risk to people of their needs not being met.

Staffing levels were adequate and good recruitment procedures were in place.

Requires improvement

Is the service effective?

The service was not always effective. People's rights may not have always been protected because the provider had not applied their practice consistently in relation to the requirements of the Mental Capacity Act 2005.

People who used the service were happy with the level of skill shown by their regular care staff, but less so of replacement staff, whom they found were not as knowledgeable or skilled.

Staff received training, support and regular supervision.

People were supported to meet their nutritional needs and to maintain good health.

Requires improvement

Is the service caring?

The service was not always caring. Not all care plans were signed by people or their representatives to show they agreed with and were happy with their care plans.

Overall people who used the service and relatives found that staff were kind and caring. Staff understood about people's needs in relation to their cultural and religious beliefs and respected these.

Requires improvement

Is the service responsive?

The service was not always responsive. Care plans did not always cover all aspects of people's needs.

Care staff's time-keeping was an issue of concern for some people.

People's individual diverse needs were taken into account when planning their care.

Some people said the office staff did not always promptly respond to their concerns or complaints.

Requires improvement

Summary of findings

Is the service well-led?

The service was not always well led. The provider had not informed the Care Quality Commission of incidents or events affecting the safety and welfare of people that are legally required to be reported.

Staff spoke highly of the management team and said they received good support and training. Staff received regular supervision and appraisals.

The provider monitored the quality of service. However systems to do this were not sufficiently robust to identify the concerns found during this inspection or to identify areas of improvement in practice.

Requires improvement

Browncross Healthcare Limited (Domiciliary Services)

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 27 and 28 August 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of one inspector and an expert by experience. The expert by experience was a person who has had personal experience of caring for someone who uses this type of care service.

Before the inspection took place, we looked at the information the Care Quality Commission (CQC) held about the service. This included notifications of significant incidents reported to CQC within the past 12 months.

During the inspection we spoke with 12 people who used the service and seven relatives. We spoke with the responsible individual, registered manager, care manager, human resources manager, administrative assistant and five care workers. We also spoke with a health and social care professional with knowledge of the service.

The records we looked at included six people's files and care plans, nine staff records and records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

All the people we spoke with said they felt safe with their care staff. Since the last inspection there had been three allegations of abuse. One of these had been investigated, unsubstantiated and closed. The other two were still undergoing investigation and had not been concluded. The agency were cooperating with the local authority safeguarding team in relation to these. A number of care workers had been suspended pending the outcome of those investigations.

Some of the people using the service and relatives reported that care workers were late for visits (over the agency's 30 minute allowance). The effect people said this had on them indicated that this was potential neglect. Whilst information about late calls was available, it was not always easily accessible as incidents or complaints were written up in a variety of different records including individual files, monitoring calls records and in the safeguarding and complaint book. However, we were advised that there had been no other safeguarding incidents by office staff other than those known to us.

In one of the communication books we found a call logged about a family member who had expressed concern that a member of the care staff had been 'too rough' with their relative. The log stated that the staff member was replaced with another member of staff. We were concerned that no other details were available when requested, including the nature of the 'rough' handling; and any indication of whether this had been considered as a potential safeguarding incident. There was no evidence to show whether the allegation was substantiated or not or appropriate action taken, recorded and reported to ensure the safety of people who used the service.

Staff told us they had completed safeguarding training, which was also included as part of their induction. Most staff could identify types of abuse and said they would report to the office if they were concerned. However, some staff were unsure what safeguarding adults meant and required further prompts before being able to identify signs of abuse.

Whilst the service had in place and had used safeguarding procedures to protect people, people who used the service were not always protected from the potential risk of abuse and improper treatment as the safeguarding procedures were not consistently followed.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Whilst medicine policies and procedures were in place, these were not robust enough to ensure safe medicines practices. Management and care staff advised us that staff only prompted people to take their own medicines and did not administer them. However, four care staff told us they applied moisturising creams to people who had been prescribed them by their GP. Neither the management nor the care staff recognised that application of prescribed creams was a form of medicine administration. Staff did not know the difference between prompting and administering medicines. The medicine policy gave insufficient guidance to staff about this and other important best practices in the management of medicines, for example, guidance about handling homely remedies or PRN (as required) medicines.

Records including care plans did not always clearly state when a person needed to take PRN medicines. For example, one person's care plan listed a person's PRN medicine to be taken for their agitation if staff could not calm them down. However the care plan did not make clear what actions staff should take to help calm the person down before prompting them to take their PRN medicine and what the increased signs of agitation were that would require them to take PRN medicine. The registered manager and responsible individual said that staff were told when people needed PRN medicine before visiting them. Reliance on verbal information in relation to PRN medicine increases the risk that people may be given PRN medicine when not needed and when it could be avoided. This is against good practice guidance from the Royal Pharmaceutical Society, that PRN medicines in MAR charts should be supplemented by written information about how and when to use them, for example, in care plans, to ensure safe management of medicines.

Where family members were responsible for managing people's medicines, this was not always clearly identified in people's records. Therefore there was a potential risk of confusion about who held responsibility around this. We discussed this with the provider who accepted that he

Requires improvement

Is the service safe?

needed to review and update the medicine policy and procedures. Lack of clarity with regard to responsibilities around management of medicines increased the likelihood of errors occurring which could potentially compromise the health, safety and wellbeing of people that used the service.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Risks to people who used the service were assessed, including risks associated with moving and positioning, health and personal care, falls and home environment and steps taken to minimise these. For example, office staff had liaised with professionals to assess a person who was at risk of falls and staff used moving and positioning equipment to keep them safe. There were policies on how to deal with a range of emergencies, including required actions in response to accidents and injuries in a person's home, such as contacting the person's GP and family if appropriate, calling an ambulance and keeping the environment safe. We saw records of occasions where staff had used these procedures to keep people safe.

There were sufficient numbers of staff to meet people's needs. Staffing levels were assessed and monitored on an ongoing basis through regular contact with people. Staffing levels were flexible and allocated based on individual needs, for example one individual had 24 hour care at home, whilst another had two care workers at particular times.

Care workers were knowledgeable about the code of conduct policy, which outlined that they were to treat people equally and not to discriminate on the grounds of age, race, ethnic origin, religion, disability, sexual orientation or gender.

All staff were vetted prior to commencing work. Criminal record checks were made on all staff and essential recruitment documents and records were sought and in place. Staff had been issued with information that outlined expected codes of conduct and a care staff handbook. These provided staff with good practice guidelines; how to protect and maintain the safety and welfare of people who used the service and expectations of them in relation to their roles and responsibilities.

The Service User Guide included a confidentiality statement that information was held confidentially and stored safely and would not be given to others without the person's permission, or unless there were serious concerns about their safety. We saw that people's files were kept secure in the office and electronic records were password protected.

Requires improvement

Is the service effective?

Our findings

People's rights may not have always been protected because the provider had not applied their practice consistently in relation to the requirements of the Mental Capacity Act 2005.

The Care Quality Commission is required by law to monitor the operation of the MCA and Deprivation of Liberty Safeguards (DoLS). The key requirements of the MCA were not fully understood by staff or managers, who had no specific training in this area. A number of care plans made general statements about people's mental capacity. Their mental capacity had not been assessed with regards to specific issues, as required by the Act. For example, one person's care plan stated that the person 'did not have the capacity to make decisions based on their best interests'. The particular decisions this referred to had not been identified nor was evidence available to show how this judgement had been reached.

A person was described in another care plan as having ongoing dementia and mental health needs, but the mental capacity section stated, 'client has full mental capacity to make decisions but can become confused'. It was not clear from this what action staff should take to ensure the person's needs were met.

One person's care plan noted that the family had power of attorney but did not state which family member had been awarded this legal authority nor state what areas they had power to make decisions (health and welfare decisions, financial matters or both). Management staff were unable to clarify this when asked. All the staff we spoke with had limited knowledge of the Act and its application. One care worker said mental capacity was about being, "mentally challenged and unable to make any decisions." Another told us, "you can tell if someone has capacity or not. And if you think they don't you would ask next of kin." They were not aware that a formal process was required to establish capacity and that next of kin did not always have a legal right to make decisions for people who were unable make them for themselves.

The provider had appropriately recommended the involvement of an Independent Mental Capacity Advocate (IMCA) to the local authority for one person. Whilst the registered manager and responsible individual had some awareness of and had taken action under the Mental Capacity Act 2005, they accepted that staff needed to gain more knowledge and skills in how to apply the Act and that training was needed to raise awareness in this area.

The failure to consistently act within the Mental Capacity Act 2005 was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us that they were happy with the level of skill shown by the regular care staff, but less so of replacement staff when regular staff were unavailable. Positive comments included, "Carers are well trained and we are happy with the care given." A relative told us, "The carer workers are very skilled and know how to care for my wife. Sometimes they tell me they have to attend training so they can't attend on those days." Other feedback included, "Regular carers know you inside out and are fantastic. Not so the other carers." This was a common theme expressed by people and relatives we spoke with. Some felt that communication could improve between replacement staff and the office. The registered manager said the difference in how care was delivered was likely to be due to regular care staff being more familiar with people's personalised care preferences in a way that would take relief care workers more time to find out. However, we found that the agency did not have robust systems in place to ensure continuity of personalised care when there were changes among staff, such as care plans providing sufficiently personalised information about individual needs and preferences.

We asked staff about their training. Staff received core induction practice and theory training and updates for topics the provider considered mandatory. The majority of staff said they were happy with their training whilst others said they could benefit from more to help develop their knowledge and skills. The field supervisors and care managers assessed the knowledge and skills of staff during their probationary period and observed their practice whilst on duty.

A number of staff had achieved national vocational qualifications in health and social care and some others were qualified nurses, however nursing care was provided by community nurses. A number of staff had completed specific training to meet the needs of individuals, for example, management of epilepsy, to support people with this condition.

Requires improvement

Is the service effective?

Staff told us they received supervision and appraisals. We saw records of supervision and annual appraisals in their files. Care staff had group meetings and individual supervision. Supervisors checked staff knowledge in a range of issues in their supervision meetings, including people's needs, care plans, policies and procedures. We noted in the meeting records of one employee, the care staff member had stated that training and personal development on the job were areas where they wished to have additional support. The supervisor had not recorded what areas of development or training was requested or needed and no action plan had been developed or evidence of follow up. The registered manager said they knew the training that staff wished to have and organised this for them. However records were unable to show if set objectives had been achieved in all cases and that staff were being adequately supported.

Similarly, we noted that annual performance appraisals did not produce any action plans, making it difficult for the provider to demonstrate in subsequent appraisals or supervision that staff achieved their goals and were adequately supported to carry out their duties and responsibilities.

People were supported to meet their nutrition and hydration needs as identified in their individual plans. We saw assessments and involvement from other professionals where their input was needed. For example a speech and language therapist had assessed that one person required supervision whilst eating. Their care plan included this information and records showed that staff were doing this. Their risk assessment noted the type of diet they required to manage their health condition. One person was assisted to have a lactose-free diet. Another liked to have African meals and an African care worker was assigned who could prepare their preferred meals.

People were supported to maintain good health and have access to ongoing healthcare support. Staff promptly made referrals to relevant health services when people's needs changed. In one case when a member of the care staff found a person who was displaying acute confusion, they contacted the GP who visited and prescribed antibiotics to treat an infection that had caused this confusion. The provider kept records of regular contact with professionals.

Requires improvement

Is the service caring?

Our findings

Overall people who used the service and their relatives told us that staff were caring and kind and treated them with respect. Some spoke highly of the care staff and made comments such as, “Couldn’t fault her” and “The regular girl is lovely.” One relative told us, “We’ve had care from them for three years. The agency and the care workers are absolutely fantastic. I love the carers.” We also saw comments logged in the telephone monitoring records such as, ‘Happy with carers. Very pleasant and they know what they need to do’ and ‘could not say enough good things about [staff member]’. One person told us, “The girls who come are all very nice and cheerful.”

Care staff told us they would stick to a person’s preferred care routine, always close doors, always ask people before undertaking any tasks and would give people choices.

According to their feedback, we found that people who used the service and their relatives had variable experiences with office staff if staff were running late. Some said office staff always called to let them know, that they never experienced any problems in this regard and that office sent someone else if they needed to. Others told us that office staff did not always respond quickly enough if staff were running excessively late (over the 30 minute allowance). One person said, “I don’t get any phone calls to say they are coming late or not turning up.” A number of other people told us the same for very late calls. One relative told us that when a member of care staff was late by some hours and after several phone calls to the office, office staff had told them that no care staff were available.

The provider had a policy of contacting people if care staff were running more than 10 minutes late. Care staff mentioned that office staff routinely contacted people when they were running late and the records we looked at appeared to support this. One care staff member told us, “I find the agency promptly responds to any issues people have. For example, if a district nurse is late or fails to attend to a person who needs their incontinence pad changing, the office will follow this up and arrange someone to get there. They always follow up.” However this was not always consistent with the verbal feedback we received from a number of people and relatives who said they experienced a lack of responsiveness from office staff and indifference from care workers when care was much later than the scheduled time, which they said had an impact on them.

People were asked about their needs, preferences and expectations before using the service and on an ongoing basis. Before the service began, a needs assessment was carried out by the care coordinator or domiciliary care manager. The care manager we spoke with advised that with the person’s permission they also consulted relatives, friends and their social worker (where appropriate) for relevant information in relation to the person’s care. People told us they were given information about the agency, their care and contact numbers before care commenced..

Office staff said that new care staff were usually introduced to people in person by one of the managers or people were advised by telephone that a new member of care staff would be providing their care. However we received several comments from people that they were not always told when new people were coming.

Staff understood about people’s needs in relation to their cultural and religious beliefs and respected these. One care staff member said, “You have to respect what they want. It is their house you go into. One lady I visit is Muslim and I take my shoes off and wear the footwear they prefer me to wear.”

Not all care plans were signed by people who used the service or their representatives to show they agreed with and were happy with their plans. The registered manager said people showed their agreement by signing their service contracts. However the contracts did not outline what service people were receiving and the provider conceded that this was not a good indicator of their agreement to their specific care plan. When asked, some people knew what their care plan was and said they were involved in its development. Others said they didn’t know what their care plan was or if they had one. Care staff who visited people said that all the people who used the service had copies of their care plans in the home.

The office managers told us they would go through individual care plans with staff before they visited people. Staff confirmed this and said they read the care plan before visiting people and would check people's preferences before providing care. The care staff told us they respected people's wishes and their right to refuse care. They described how they encouraged people if they refused care or would speak with their manager to review the person’s needs and care provided.

Requires improvement

Is the service caring?

The provider gave people a service user's guide when they began using the service, which provided useful information. This included a summary of the terms and conditions, the complaints procedure, what people could expect from the service, respecting their rights to make informed choices, home visits and key policies and procedures.

Requires improvement

Is the service responsive?

Our findings

People were at risk of their individual needs not being met as care plans did not always cover all aspects of people's needs. For example, one care plan stated care staff needed to support a person's mental health through close supervision and reassurance, but did not state how. When asked, management staff described the indicators of the person's deteriorating mental illness and when to involve other professionals. However this information was not included in the person's care plan, increasing the risk of the person not receiving adequate support.

Care plans did not all record support and care arrangements provided by family members. This increased the risk of confusion, duplication of care or of people's needs not being met.

Personal preferences were not always clearly stated in care plans. Whilst management staff said they and care staff knew anecdotally what people's preferences were, this increased the risk of some people not receiving care according to their wishes. This was reflected in some of the feedback we received from people who used the service and their relatives.

We had mixed feedback from people regarding time-keeping and care staff. People said regular care staff were, "Great" and "usually on time," and "pretty good through the week". A relative told us that timekeeping was, "Phenomenal, can't fault them at all with timekeeping." Similarly another said, "The main carer who comes Monday to Friday is brilliant."

However, we also received a number of negative comments about time-keeping. Whilst the policy allowed an additional thirty minutes to scheduled call times, those with negative experiences told us some care staff had been much later or had missed calls altogether. Some said this was hours after the scheduled time. A relative said, "Last night the call should have been 7.30 to 8pm but they arrived at 9.15pm. This was almost a redundant call. The lunch time call should be about 12.30pm but has been as late as 3pm which makes the tea time call due at 4 to 4.30pm difficult." They explained that late calls were a problem because their [family member] needed to take their medicine with food.

Some people said weekends were more of an issue for them. For example, one person said, "A few Sundays ago no one came and I rang the office. They said they were on their way and the carer arrived at 11.45am for the first call, just before the lunch call." Similarly, we received the feedback, "Week-ends could be anywhere between 9.30am –12 noon." Some people said they were always informed if staff were running late, others said this did not always happen.

Records in individual files showed that management staff took action when advised that care workers were running late. They had contacted people

and their relatives to advise them if staff were running more than 10 minutes late and arranged replacement care workers. We were told that field monitoring officers placed in each of the London boroughs covered by the service stepped in and provided care and support whenever necessary.

However, the verbal feedback we received from people did not reflect this level of care or consistency. Some people told us about the inconvenience and impact on them of excessively late calls or as one person said, being left to "Fret with worry."

We spoke with a health and social care professional who was in regular contact with one person who used the service. The person's feedback to them reflected the experiences of people we spoke with. The person said the response from office staff could vary, that one staff member they dealt with was really helpful, very responsive and acted quickly. But this was not always the case with other office staff when they called, particularly at weekends.

The above issues relate to a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Approximately 80 people were using the service. People were who used the 'reablement' part of the service made good progress in their rehabilitation towards independence at home, for example, after hospital discharge. This was by using the short term care service provided by the agency. Staff were in close contact with other professionals as part of this service. The managers said this partnership worked well and people made good progress following the care they received.

People were supported to be as independent as possible. Several people gave positive feedback about their support, including, "We had many hiccups previously in care but now life has been so much easier to manage. The personal

Requires improvement

Is the service responsive?

assistant works with me and the needs we have to support my son." Telephone monitoring records mirrored these comments, such as 'Wife is happy with improvement of girls' and 'Very happy with the service. [The person] is now independent'. Care staff told us that people received a good service and made good progress in their ability to care for themselves. People's needs were reviewed and professionals and relatives (where appropriate) were invited to attend to exchange feedback.

Care staff were allocated according to their ability to meet people's needs and where the person lived. The provider took into account people's diversity, cultural and religious needs when arranging their service, such as allocating care workers of the same gender or who could speak the same language.

People were advised about the complaints procedure and knew how to complain. The complaints policy and procedure were outlined in the service users guide. Feedback from people and their relatives about their experience of the provider's handling of complaints was divided. For example, one relative said, "I have no complaints at all. The service is fantastic." Another said, "Great, no problems and I have no complaints." One person said they could not see "eye to eye" with care staff and told the office which led to those staff being replaced.

Others were less satisfied, with comments such as, "I have complained to the office before but sometimes it feel like it's crossed wires." Another person said they felt the supervisors and office staff communication was not good and said, "They don't seem to listen and not come back when you make contact many times asking for information." A relative said, "Mum gets stressed and frustrated with late calls. I have contacted the office with concerns but they don't ring back."

There were seven recorded complaints in the complaints book. These were responded to and appropriately dealt with, with the exception of one which required more detail to establish if it needed handling under the safeguarding procedure. For example, office staff replaced members of the care staff when people requested and spoke with care staff about time-keeping or performance. The provider liaised with other professionals where appropriate to make them aware of any concerns and sought their input to assist people.

Complaints and concerns were also recorded in quality monitoring sheets. We saw that where people's concerns were recorded, these were responded to and follow up calls made to ensure people were satisfied with their care. Care staff told us that complaints were well handled. They told us they were not aware of any current complaints and said the provider always promptly responded to any concerns. One said, "The agency and managers are very good. They always respond to people's needs. If people have any concerns they always visit and investigate and try to help." Managers told us they would frequently visit people to address any complaints and records we saw confirmed this.

We found that it was difficult to ascertain how many complaints the provider had received and if dealt with in a satisfactory way. Complaints were recorded in different documents, such as telephone monitoring sheets, daily records and the complaints book. This made it more difficult to analyse complaints, identify any patterns to complaints, issues or concerns and how these were actioned in each case.

Requires improvement

Is the service well-led?

Our findings

We found from records and feedback we were given that there had been incidents and safeguarding allegations which required notification to the Care Quality Commission (CQC). The provider had failed to inform CQC of significant incidents or events affecting the safety and welfare of people, which are required to be notified by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009

When asked how the service promoted a positive culture, one of the managers said the care was person-centred as they consulted and involved people and used their views to develop their care. We found that feedback from people and their relatives who used the service was variable about this. The provider was satisfied that people were happy with their care and the service overall. Whilst this was reflected in the majority of comments in records from home visits, monitoring calls and the latest annual survey, we were concerned about the extent of mixed verbal feedback from people and their relatives about their care, the organisation and management of the service.

Some people spoke in positively about the organisation and management of the service and said they thought the management was very good. Others were less than satisfied and thought there were areas that needed improvement. One person said, for example, they found some office staff very efficient and well organised, responding to any of their issues very promptly. Then occasionally they found other office staff not as efficient or to be as well organised.

Another person said they felt that office communication with them was at times an issue. This was reflected in a similar comment, “There is a breakdown in the office communication as I cancelled this weekend. But at 7am on Sunday I was awakened by care staff using a key box.”

The registered manager said most of the quality service monitoring went on in the community by field monitoring officers, who were in regular contact with people.

The agency sought feedback from people in line with their monitoring policy. People were contacted within one week and again one month after they started using the service to check if they were satisfied. This included checking that staff were carrying out the agreed tasks to the standard expected. Any comments were recorded in the person’s file. Overall records showed that action was taken to rectify areas in which the person stated they were not happy. People received visits at least every three months to monitor the service, but managers and staff informed us that visits usually occurred more frequently.

As part of the quality monitoring process, managers took it in turns to visit homes to check that all required records and documents were in place. The provider also took into account regular feedback from staff who were in frequent contact with people and their relatives. Formal written feedback was sought in annual surveys and in reviews.

The telephone monitoring book recorded dates and times of calls to people and the outcome of conversations. The vast majority of comments showed people were either happy or very happy with the service. Between October 2014 and May 2015, 74 people were telephoned, and 72 people said they were happy, very happy or extremely happy with the service. Two people said they were not happy with their care staff and we saw that the agency took appropriate action in response.

The agency’s annual satisfaction survey was completed on 31 January 2015. Responses were received from 45 people who used the service and showed that a high percentage of these people were satisfied in relation to the care provided; punctuality; care staff being courteous and helpful; being kept informed of changes to care; documents being kept in the house and back up staff arrangements.

However, whilst the provider had quality monitoring systems in place, these were not sufficiently robust as they had not identified the concerns we found during our inspection. This had the potential to impact on levels of satisfaction, safety and wellbeing of people who used the service. Lack of effective quality assurance and monitoring systems increased the risk that areas of poor practice may not be identified and addressed.

This is a breach of regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Staff spoke positively about the management team. One member of the care staff said, “I’m really enjoying working for the agency.” We received similar comments overall, such as, “The agency are very good. They really look after clients and staff.” All the staff we spoke with said they

Requires improvement

Is the service well-led?

received good support, supervision and regular training and were kept up to date with information they needed. Records of team meetings showed these were regular and a range of issues were discussed in relation to the service.

We saw the provider's annual business appraisal for 2014, which reported that the year had been a challenging one, with increased frequency of home visits and spot checks. The report re-stated the aims of the service, but did not include any views or experiences of people or their relatives about the service. The evaluation did not set out what goals had been achieved nor identify any form of action plan to further improve or develop the service, using an analysis of people's views, identifying any patterns, learning from incident and complaints or the results of quality monitoring. The provider said ongoing improvements and changes were implemented immediately after people raised any issues or complaints, but conceded this was not reflected in their business report and plan.

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 13 HSCA (RA) Regulations 2014 Safeguarding service users from abuse and improper treatment People who used the service were not always protected from the potential risk of abuse and improper treatment as the safeguarding procedures were not consistently followed. Regulation 13(1)(2)(3).

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment The provider did not ensure that service users received care in a safe way as medicines were not managed safely. Regulation 12(1)(2)(g).

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent The provider's practice was not always consistent with the principles and requirements of the Mental Capacity Act 2005 in order to protect the rights of people. Regulation 11(1)(3)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

This section is primarily information for the provider

Action we have told the provider to take

Regulated activity	Regulation
	The provider had not ensured that service users care was appropriate and met their needs as assessments and care plans were not designed in a way that achieved people's preferences and ensured their needs were met. Regulation 9 (3)(a)(b).

Regulated activity	Regulation
Personal care	Regulation 18 CQC (Registration) Regulations 2009 Notification of other incidents The registered person had not notified the Commission without delay incidents or allegations of abuse in relation to a service user. Regulation 18(2)(e).

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance The provider was not operating effective systems to assess, monitor and improve the quality of the services provided, did not always assess, monitor and mitigate risks and did not always seek and act on feedback from relevant persons. Regulation 17(1)(2)(a)(b)(e)(f).