Time 2 Care (BSE) 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?	Requires improvement
Is the service well-led?	Good

Overall summary

The inspection took place on the 18 January 2016. We gave the provider 62 hours' notice of our intention to inspect to give them time to arrange visits to people using the service. The agency gained consent ahead of our visits and we visited 15 people to ascertain their views of the service.

The service is registered to provide personal care to people and currently supports about 150 people with domestic, social and personal care support.

There was a registered manager in post.

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.

People's views of the service were positive and staff enjoyed working for the agency. Senior staff knew people well and care calls appeared to be well coordinated with

Summary of findings

most care staff having regular rounds with minimal travelling. However there had been some missed calls, the last being the day before our inspection. This potentially putting people at increased risk of harm.

People were supported to take their medicines [where required] by staff who were trained to do so. However we identified a number of issues and did not feel the auditing of medicines was sufficiently robust.

Staff were given sufficient training and induction into their role to enable them to deliver care effectively. Staff understood their responsibilities and their performance was monitored to ensure they had the competencies and skills for their role.

Risks to people's safety were not always fully assessed and we found record keeping required improvement as it did not always accurately reflect people's needs or take into account changes which had occurred. This meant staff were not always sufficiently knowledgeable about people's needs and we found they did not always have sufficient time to deliver the care the person needed.

Staff understood how to promote people's safety and independence. Staff had been provided with training in the Mental Capacity Act (MCA) 2015 and Deprivation of Liberty Safeguards (DoLS) and understood the principles of consent and best interests. The MCA and DoLS ensure that, where people lack capacity to make decisions for themselves, decisions were made in their best interests according to a structured process. However, people's preferences were not always recorded. Staff had a good knowledge about how to safeguard people in their care and report any changes or where they had concerns about people's well-being.

The service was well led with staff working together as a team and having a clear understanding of theirs and others roles. There were clear lines of accountability and staff were well supported. There were sufficiently robust quality audit systems which took into account people's views and experiences which were used to change and improve the service as required.

We found a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 in one regulation. You can see what action we told the provider to take at the back of the full version 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?

Requires improvement

The service was not always safe.

Risk assessments did not always accurately reflect the person's needs or the environment in which care and support was taking place in.

People received their prescribed medicines safely by staff who were trained to administer them. However errors were not quickly identified because auditing processes were not robust enough.

Staff knew how to report concerns and protect people against possible abuse or avoidable harm.

There were sufficient and suitable staff recruitment processes in place.

Is the service effective?

Good

The service was effective.

Staff were guided through induction, training and supported to deliver care which met people's individual needs.

Staff supported people appropriately and had enough understanding of the Mental Capacity Act 2005 which enabled them to support people lawfully.

People's health care needs were met.

Is the service caring?

Good

The service was caring.

People had positive experiences of care.

Care staff supported people well and promoted their independence and dignity. Staff treated people with respect and in accordance with their wishes but these were not always recorded.

People were consulted about their care needs and the service provided was centred on the needs of the individual.

Is the service responsive?

Requires improvement

The service was not always responsive.

People had their needs met by staff who knew them well. However the standard of record keeping did not always reflect this and care plans and risk assessments were not always accurate. This could result in inconsistencies in care.

The service had an effective complaints procedure and acted upon concerns raised.

Summary of findings

Is the service well-led?

Good

The service was well led.

There were clear lines of accountability and a real drive and commitment to improve the service wherever it could and supported staff to deliver high standards of care.

The service worked in cooperation with other services and asked for regular feedback from people using the service. This helped them identify what they were doing well and where they might need to improve.

Time2Care (BSE) Ltd

Detailed findings

Background to this inspection

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

The inspection took place on the 18 January 2016 and the inspection was announced. We gave the provider notice ahead of this inspection because the location provides a domiciliary care service and we had asked them to arrange for us to visit people in their own homes.

Prior to the inspection we looked at previous inspection reports and notifications which are important events affecting the service which the provider is required to notify us of.

The membership of the inspection team included four inspectors one of whom was on their induction. We visited fifteen people during our inspection and spoke with a number of relatives. Whilst visiting people we looked at their care plans and medication records. In the office we interviewed six care staff and spoke with senior staff responsible for managing the business. The registered manager was not present but all other members of the senior team and administration were. We looked at records relating to the running and management of the business.

Requires improvement

Is the service safe?

Our findings

People did not always receive a service which was safe and met their needs. One person told us, "I didn't have anyone visit me yesterday. There was a bit of a muddle. When I let them know they said it wouldn't happen again but they didn't send anyone along later." This person was extremely frail, only able to stand for a very short time and said that they became "dizzy at times". They said that they were only able to wash their face and hands by themselves and "had a job to get dressed". The agency said they had not been notified in a timely way of this missed call which meant they had been unable to send an alternative carer.

Other people said they had never had a missed call and if staff were running late for any reason the office staff called to let them know. Another person told us a carer was running 45 minutes late the morning of our inspection but said they called them to let them know. They said they had never had a missed call and it is unusual that they were running late.

We looked at the computerised system which logged all the calls. Time specific calls were logged and priority calls were logged as red and this was then highlighted on staff's timesheets. For example we saw that a person who had regular hospital appointments and a person with time specific medication needs were both highlighted as a priority. The nominated individual told us that if a new person needed a service and they have time specific needs they would not be taken on if the service cannot meet their needs.

We identified that there had been eleven missed visits in the last six months. Staff told us two of these had been due to the person cancelling their visit. The nominated individual assured us that missed calls would be a thing of the past as the company were investing in an electronic monitoring system. This would help track staff and know when they arrived at the person's home and when they left. This had already been trialled in their other branch and proved to be a good quality monitoring tool which should eliminate missed calls.

People had risk assessments in place. These told staff things they needed to take into consideration and how to meet people's needs safely. For example manual handling, mental health and where people had specific equipment and, or emergency alarms. Staff said they had the equipment they needed to support people, had been trained to use it and there were risk assessments in place. However risk assessments seen did not always accurately reflect the needs of the person or the environment the person was being cared for in. For example one risk assessment referred to stairs and hoists (neither was present at this address.) Some of the information was out of date which could increase the risk of unsafe care. For example one person's records made reference to using 'a rolater turntable,' which we found was no longer needed. Care staff told us that the care plans did not always include sufficient detail. For example one person's manual handling plan said the person used a zimmer frame and staff should keep close to support and assist them. It did not say what the risks were to the person or anything else which might impact on their mobility.

People and the relatives we spoke with told us that they felt safe when staff were in their home. Staff showed their identification badge when they first visited and were always in uniform. One person told us, "I feel safe and I trust them." They said that staff in the office told them if a different care worker would be visiting. A relative said, "They usually notify us if there's going to be someone new."

One person told us staff assisted them in the bathroom and did not leave them alone, which made them feel safe. However, they said, "One of the carers comes out of the bathroom. I don't know why they leave me as I don't feel safe when they leave. They expect me to wash parts of myself, which is difficult as I have to hold on." They told us, "I did slip off the chair one day when they were out of the bathroom." Their risk assessments were not in sufficient detail resulting in differential care practices.

One person raised concerns about the manual handling practices of staff. They said staff sometimes rushed them and some staff were not confident in using the hoist but reported that things had improved. They felt the training of staff was not sufficient and it took time for carers to gain sufficient experience. They said the agency refused to remove the sling after each move, to and from the commode and to and from their wheelchair. Their care plan stated that the sling should be removed between each move onto the toilet and into their wheelchair. However, despite this being in their care plan care staff said it took

too much time. The person told us, "It's extremely difficult to go to the toilet with the sling in place." The person's relative felt the time given for the visit was a contributing factor and resulted in carers rushing.

This demonstrated a breach of Regulation 12. Safe care and treatment.

Safe practice around medication administration was promoted through adequate staff training and staff had at least three assessments of their competence to ensure that they had understood the training they were provided. Staff's medication practices were then assessed at least annually, sometimes more. Where people required pain patches the district Nurse came in for the first visit to show staff where the patches need to be positioned. A senior carer was also present for the first visit or until the staff member felt confident to continue to do it alone.

There were systems in place to identify and address poor staff practice in relation to safe administration of medication. The agency had raised safeguarding concerns around poor medication practice and staff were retrained and supported to ensure they were familiar with policy. Medication records were checked as part of quality assurance processes. Last month's MAR charts and notes were brought into the office and current ones left in the folder.

However we did have some concerns around medicine practices raised with us. These included: A relative told us that staff did not always monitor the amount of medicines left and had to remind them when they needed to reorder medicines. Staff were responsible for administering the majority of this person's medication. Their relative said, "On one occasion staff only told me the medicines were going to run out two days before the new batch should have been started." This had resulted in them having to visit the surgery and pharmacy to get the new prescription dispensed.

Medicine administration records (MAR) were typed by the office staff with the medicines staff needed to administer. The forms stated that they had been checked for accuracy by two members of staff, which is good practice. However, one person's MAR did not fully reflect the medicines that staff should be administering. Staff had handwritten some entries and crossed others out. This was confusing and could potentially lead to errors. A painkiller that was prescribed three times a day was only typed on the MAR for one dose a day. In December 2015 the care staff had added the medicine for the second dose but not the third dose. According to the MAR the person only received two doses of their medicine during that month. A number of people had a range of different topical creams. However, their care plans or the MAR did not always state where the creams should be applied.

There were no clear records of how the service audited its practices around medication. The care manager told us MAR sheets were brought into the office monthly and checked but was not able to provide evidence of this because records had since been archived. However there were processes in place so recording errors of this kind could be easily identified and regular spot checks on staff practice included a check on people's records.

We identified a concern where staff were crushing and administering a person's medication on the agreement of their full time carer. We explained there needed to be a risk assessment in place and consent to do this preferably from the GP. We had the opportunity to talk to the Next Of Kin and clarify the situation. We have since received a copy of a letter from the GP giving the agency permission to crush medication which they were also administering covertly. We are satisfied proper procedures are now in place. We also noted that the care plan needed to clearly illustrate the level of support the person required. The agencies own medication policy used a traffic light system, green for no assistance, orange from prompting and red for administering. However we found that in some care plans people had more than one instruction based upon assessment about administering medication which gave different information about what support a person required.

This demonstrated a breach of Regulation 12 Safe care and Treatment.

The service had enough staff to deliver care to people. Missed calls were as a result of human error. The agency had systems in place to provide care between seven in the morning and ten at night with the office operating between nine to five and an out of call number for other times. The Care co-coordinator said they carried out frequent spot checks to ensure staff were delivering care effectively and they had a number of quality assurance systems including direct feedback from people using the service to ensure it was provided to a high standard.

Requires improvement

Is the service safe?

Risks to people's safety were managed as far as possible. Staff demonstrated a good understanding of how to keep people safe and knew to report any changes or concerns they had about people to the office immediately. Staff spoken with confirmed they had received training in the protection of vulnerable adults. They felt confident in raising concerns and also had knowledge about whistle blowing and referring concerns both through internal processes and to external agencies. They referred to body maps which they used to record any unexplained bruising or marks they might notice when supporting people.

People were not adequately protected from financial abuse. The finance policy makes no reference to what staff could or could not support people with. There was no reference to store loyalty points or using people's credit cards of their behalf. We identified this was happening? We would not expect staff to do this and felt there were insufficient safeguards to protect people from financial abuse. The service were currently supporting a person by buying them a lottery ticket each week at the person's request. We suggested the financial policy should clearly reflect the risks and actions expected of staff.

The service had appropriate recruitment processes in place to ensure any staff employed by the service met the agencies criteria. We looked at three staff records. They were well organised and included disclosure and barring checks to ensure staff had not committed an offence which might make them unsuitable for employment. There were application forms including employment history, references and personal identification and confirmation of address. Staff files contained evidence of induction and training undertaken at both previous and current employment. We could not always see when staff had completed their probationary/induction period and asked for this information to be added to the front of staff files.

Good

Is the service effective?

Our findings

Staff showed a good awareness of the Mental Capacity Act 2015 and how it should be implemented to ensure people were supported lawfully. They were able to give us examples of their involvement with the Local Authority where a person's mental capacity to make decisions was in doubt. However the paperwork in people's homes needed to improve to reflect actions taken by staff to support people appropriately with their care needs. The provider had a policy in place and staff had basic training on the MCA.

People and their relatives told us that staff had the skills to do their role. One person said, "They know what they're doing. They seem experienced. New staff have more experienced staff with them." Another person described care staff as, "Very professional". A relative described the staff as, "Experienced" and added "They all know what to do."

A relative told us that there had been some turnover of staff. They felt that this was in part because their visits were not organised in such a way as to reduce mileage. They said, "Staff have to go all over the place, crossing town all the time. Visits don't seem to be coordinated. A few staff left because of this." However this is not what we saw, visits were organised mainly according to staffs location but this was less so at weekends with staff having to travel further.

Staff told us the training they had was very good, One staff said, "The e-Learning is a bit monotonous but the dementia training was really good." New staff said they had training which was thorough and lasted about a week and was mostly classroom based, practical training. Staff said they could request training which they felt was relevant to their role and they had regularly updated mandatory training. Training was provided in a variety of ways both face to face and through e-learning. Multi-choice questions and answers tested staffs knowledge. We looked at staffs training matrix which indicated green where training was up to date, amber when due and red when overdue. Some staffs training was overdue but we were assured this was being addressed. Some training was person specific. For example one person was being supported with their meals taken intravenously and staff had been provided training by the dietician and staff signed off as competent to support that one person. Other examples of recent training included diabetes, resuscitation, intensive dementia training and managing in-continence. The majority of the staff team [about 90%] had completed enhanced qualifications in care or had been enrolled. There was a pay enhancement for staff undertaking advance study. Seniors had completed courses appropriate to their role such as a risk assessment course. Some staff had completed end of life care provided through the local hospice but this had not been extended to all staff.

There were some gaps in staffs knowledge and available training. Some staff said they would like to do more around pressure care and r catheter care. The service did not utilise the skills of their care staff. They were matching staff to people based on their postcodes rather than their skill set.

We spoke with newly employed members of staff who told us they had two shadow shifts. This was the same for two other members of staff spoken with. All three had experience in care and held enhanced qualifications. The care manager said staff were given as long as they needed depending on their level of experiences and confidence. Staff records showed a record of induction and who inducted them. Continuous feedback about their performance enabled the care coordinator to make an assessment of their capabilities. The agency had started to deliver the new care certificate which is a national induction programme designed to ensure that new staff have the knowledge that they need for their role.

Staff spoken with were positive about the agency they worked for. They told us there was great team work and regular support and training. Staff said they had area team meetings and there was one planned on the day we inspected. Staff said they received either face to face or phone supervisions usually some of each. Spot checks on staff were described as regular. (every three months.) This was to ensure staff were where they should be and were following company procedures and following the care plans when assisting people with personal care. Annual appraisals of staff performance were also completed for all staff.

Some people we spoke with had regular contact with health professionals, who monitored their health needs. However, some people did not see health professionals on a regular basis. There was no evidence in the care records that staff were monitoring people's medical conditions. However, a relative told us, "The older carers really check

Good

Is the service effective?

them over and check they're OK." A person told us, "Care staff have suggested that I needed to see the doctor." People with insulin dependent diabetes told us that they received regular chiropody.

People were supported with eating and drinking enough if this was a task identified as part of the plan of care. We saw evidence of how staff were recording what people were eating and drinking to help them evaluate if people were eating and drinking enough for their needs. One relative told us they had not got the patience but staff spent a great deal of time assisting their spouse to drink at every opportunity.

Good

Is the service caring?

Our findings

The service was caring and staff knew people they were supporting really well. They aimed as far as possible to provide a reliable, regular service with the same carers supporting people. The care manager told us that each year they sent out Christmas cards to everyone using the service. The service were able to demonstrate how they supported people and went the extra mile. Two examples included, one person being supported said what they really wanted was a day at the sea side. Staff arranged this by initially contacting social services and putting arrangements in place. Two staff took them. Another person was assisted with redecorating their property as they were unable to do this for themselves.

People we spoke with considered that the majority of care staff were very supportive. People and their relatives were complimentary about the care staff, describing them as "Efficient" and "Thorough", "Very good and kind", "Cheerful and bright" and "Wonderful". One person said, "The staff are very nice people. They are very respectful. I like the way they support me. We're very happy to see them." Another person told us, "They are very polite, there's no problem there. I like to have a laugh and joke with them." A relative said, "They fit in when we have family visiting so we feel comfortable."

One person they usually have one specific carer, but did not mind as long as someone came. They said very occasionally they had someone that "I don't really fancy, but most of them are very nice." They said care staff treat them with dignity and respect and they could not think of anything that could be done to make the service better.

We observed the care of a number of people during our visits to their home. We observed staff asking the person about their preferences and how they would like care provided. Staff were courteous and considerate and asking permissions such as did the person want their curtains opened. Staff were friendly and chatty.

People told us that they were asked what gender of care worker they preferred and said that their preferences were respected. One person told us, "I prefer a female carer and that's what I get." Another person said that they preferred the more mature care workers. They told us, "I feel one of them is too young. I get embarrassed with them but not the older carers."

People and relatives told us that staff respected confidentiality. One person said, "They never mention anyone else that they visit."

Another person described care staff as "extremely kind" and "as friends". They said they are usually punctual and came at the times requested. They said they were very polite and respectful of dignity. Their relative said, "The carers are so wonderful. They help me a great deal. "They are more friends than carers, and are so caring, so cheerful. I admire them all."

However two people did not consider that all staff promoted people's independence and helped them to maintain their abilities. They said, "[The person] isn't allowed to wash themselves because of time constraints." Another said they sometimes felt that the visits are a little rushed, some will have a chat and some do not stay for the full 30 minutes.

People told us they were consulted about the service. They said when their care plans were first put together they had been involved in what went into it. Another told us that their needs had reduced over time and they had been involved in reviewing their care plan to reflect this.

Requires improvement

Is the service responsive?

Our findings

We found information about people's care needs was not always sufficiently detailed and could result in care not being consistently provided. Some staff felt care plans were insufficient in detail and other staff said they did not always get enough information ahead of a visit. They said this made it difficult to meet the person's needs particularly where the times of the calls were limited. Staff said care plans could be more thorough with details about how to support the person and they were not very person centred. One staff member told us "I don't think I could go to a house, open the care plan and know what to do and how to do it or how the service user would like me to deliver the care. There have been situations when I have felt unclear."

The care manager told us that after receiving an initial assessment they would visit the person they were going to provide a service to and put in place an initial risk assessment and record the person's basic needs. They said this is developed over a period of time as they got to know the person better and more about their likes and abilities. They said there was a review after about six weeks of them providing the care and then again annually depending on the level and complexity of the person's need. Reviews would be more frequent where needs were constantly changing.

People's care records required improvement to accurately reflect people's needs and to ensure all staff worked in a consistent way. We visited one person who had very detailed information about their manual handling needs which had been updated annually but other information was not as thorough. For example this person had complex support needs and the care plan gave briefest of instruction such as assist with medication. Staff were administering medication by crushing it and disguising it in food, this was not recorded. The person had fluctuating needs in terms of eating/drinking and staff did support them with this task but their care plan did not say how staff should monitor this and as the person was in bed all the time there was nothing about the risk of aspiration. The person had also developed very sore skin/which we were told was broken but there was nothing in the care plan about how staff should promote skin integrity. Another person's record had incorrect details of the person's doctor and next of kin, Another record said a person needed assistance with medication where in fact they told us they took their own medicines. Routine and tasks in some care plan had not been updated and were not a reflection of current needs and of preferences.

The care records were confusing as they contained a considerable amount of information that was not relevant to the individual person. For example, information on staff dress code and information on catheters and stoma bags when the people did not have catheters or stomas. Most of the care plans stated that staff should use the 'daily routine and tasks' as a guide to the provision of care. However, the daily routine was often only a couple of sentences long. There was no mention of people's abilities, preferences or how staff should monitor their medical conditions. They were also not always up to date with people's changing needs. Some people had a number of different medical conditions and very complex needs including insulin dependent diabetes. The records for one person stated that staff should provide catheter care. However, there was no detail as to what and how this was to be provided by the staff. The lack of detail in the records would be likely to lead to inconsistent care practices.

This demonstrated a breach of Regulation 12: Safe care and treatment. .

The agency had an established complaints procedure and made the information available to people using the service. When we spoke with people about this they were aware of how to make a complaint. One person told us they had never had to make a complaint but knew the process if they needed to. One person told us they raised a concern about a staff member and the agency dealt with this and told the person how they had dealt with it.

We looked at the complaints file and saw that there was a process in place for dealing with incidents and complaints. Questionnaires were given out to people using the service and their relatives to give feedback on the service they received. It was an opportunity for them to raise any concerns that they have. Suggestions were acted upon and we found the agency very responsive to anything we raised. An example of actions taken by the agency included: The ambulance crew raised a concern that if the daily records were removed from people's files there was no way for them to be highlighted to any change in medication. Now the previous month's daily records are left in people's files in their homes.

Requires improvement

Is the service responsive?

The service showed us compliments they had received about the service they provided which showed the majority of the time people were very satisfied with the care and support provided. Most people using the service and staff told us what worked really well was that care staff had the same rounds each day which meant people using the service had consistency and their care was delivered by staff familiar with their needs. People were given rotas so they knew who should be coming. The continuity of care was important to those we spoke with. They said at times there was some disruption to their usual schedule when staff went on holiday or if sick.

A member of staff told us they mostly had people in the same area and had a split rota which suited their needs and the needs of the agency. Staff told us that their care calls were usually scheduled back to back with no time to fit in additional calls should they need to. However they also said that they got paid travel time. Travel time where possible was kept to a minimum. There were staff who were supernumerary to the 'rotas' who could pick up additional calls as necessary. We were told for example the out of hours cover was provided by two seniors. If care calls needed covering the first senior would cover them and the second senior would man the telephone. In an absolute emergency temporary agency staff would be used but rotas were planned far enough ahead to ensure calls were appropriately covered. The agency had quite a substantial number of people wishing to use the service but staff told us they would not take on additional clients unless they could cover the calls. Staff recruitment was ongoing. Staff told us there were less staff at weekends but also less calls and always staff wishing to pick up extra hours. They felt the service at the weekend was as good as the service provided in the week.

Staff told us that if for any reason they were running late for a call they would notify the office who in turn would notify the person using the service. All staff spoken with said the 'office' and out of hours support was good. Staff told us most calls were for at least 30 minutes, only two calls were for fifteen minutes but that was only to administer medication. The care manager said they did try and match people's preferred time for staff to visit but this was not always possible and they allowed half an hour either side of the visit.

Good

Is the service well-led?

Our findings

People using the service and their relatives reported that this was a good agency and they felt it was well led. One relative told us they felt confident that action would be taken if they rang with any concerns. They said, "The service is excellent and I cannot think of any improvements I have complete confidence in them." Another said the service was reliable and well planned. Another said they had absolute confidence in the agency. They told us they appreciated the peace of mind that the service provided them and said that the agency communicated well with them.

Staff told us there was good support and communication between carers and any matters of concern in respect of people they were supporting was passed on. The care manager told us that newsletters and memorandums were sent out occasionally to update staff on any changes to policy. Staff had the opportunity to meet regularly and told us they were well supported.

The management team consisted of the registered manager, the nominated individual and care manager. Senior members of the team had responsibility for different areas covered by the agency and were carrying out initial assessments of care, risk assessments and spot checks on staff. Time 2 Care had two separate locations with one manager overseeing both and a care coordinator with day to day oversight of the location in Newmarket. They told us they were well supported by the registered manager and had a good local knowledge and knew people they were supporting. The organisational chart showed how the location was divided by different geographical areas with senior staff overseeing different areas and teams of staff who were local to the area to minimise travel time.

The office appeared well organised with staff holding clear job roles and having an understanding of different parts of the business, although some were relatively new and still learning. Newer staff said they had been made welcome and felt the management team worked inclusively with people and staff and were receptive to new ideas.

The service had quality assurance systems which included regular client reviews at least annually and spot checks on staff. Bi annual surveys were also circulated to help the agency ascertain what they were doing well and where they needed to improve. One person said, "They come from the office to check that everything's OK." Another person told us, "The office staff review the records but I don't see them that often."

Staff wrote the times of their visits in the daily records but people or their relatives did not sign to say that the times were accurate. One person said, "I'm meant to have half an hour but sometimes they only spend twenty minutes. It doesn't happen so much since I mentioned it to the office." They said since they had done this things had improved. Staff in the office told us they monitored people's daily records and staff time sheet regularly to ensure people were getting the care they needed and according to their needs.

The care manager demonstrated a good knowledge of other health care professionals and how they should be contacted. They clearly had good relationships with them and were able to access support for people as and when they required it. They said they sometimes worked in unison with other agencies to provide support to people. They also had good working relationships with other agencies which meant they could pull resources if need be.

The care manager showed us many compliments they had received about the service and the care they had provided. They told us about things they did to support people using the service such as negotiating a lower fee with the vet to treat a person's cat with necessary treatments and staff taking the animal to the vet as the person as unable to.

Some staff were dementia friends which meant that they had through the Alzheimer's association attended a session concerned with raising dementia awareness and accessing training and support.

The service had a number of policies and procedures which we felt could be improved upon as they were not service specific but generic. The Statement of purpose, (SOP) did not clearly determine the level of need the agency could meet and we were initially told they did not support anyone overnight but then found in fact they had. The agency has made changes to their SOP and policies to address our concerns since the inspection.

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
	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment Regulation 12 HSCA (RA) Regulations 2014. Safe care and treatment. 1. (a) (b) (c) 2 (g) The provider was not ensuring risks to people's safety was fully assessed and all steps were taken to mitigate risk as far as possible. There were also inadequate systems to ensure people always received their medicines as prescribed and in a safe way.

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.