Castle Care Wessex Limited

Castle Care Wessex

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Requires Improvement
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

Castle Care Wessex is a small home care agency which provides personal care across the South West to people in their own home. In August 2015 it became part of Berkeley Home Health after being a family run care agency. The main office is located in purpose built premises within a small business complex just outside of Frome. On the day of the inspection there were fifteen people receiving support from the agency.

This inspection was announced and took place on 12, 19 and 21April 2016.

The agency had a registered manager who was in post before the provider became part of Berkeley Home Health. 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 told us they felt safe but risks to people's safety were not identified in their care plan or risk assessments. Medication was not safely being administered and staff had not always received training. Errors were apparent on the medication administration records of one person and medicine was not always given in line with people's care plans. Protective clothing was not always being worn by staff where appropriate and whilst supporting people with personal care to prevent infections spreading.

People were not always supported by staff who had the correct checks completed or a risk assessment to demonstrate they had considered keeping people safe from being cared for by unsuitable staff.

Staff told us there were enough staff to cover the visits and had time to travel between them. Staff told us they had a good induction and lots of training. However, some training had not been identified to meet the needs of a person with additional health needs. The registered manager had not kept their train the trainer qualification up to date with current legislation and regulations around administering medication.

There were detailed care plans for all individuals including specific information for each visit. These plans had a person centred approach to them and captured the people's voice. This meant people were central to their care and any decisions made. However, sometimes there were too many versions of the care plan which could cause confusion about which was the most current. The needs of the people were reflected within the plans; most of the time they were responsive to people's changes. Staff had a good knowledge of the people they were supporting and their needs.

There were limited quality assurance procedures in place to keep people safe and they were mainly informal. When shortfalls had been identified by the provider and registered manager measures had been put in place to rectify the issue. However, the registered manager and provider had not picked up all the concerns we found. However, they were resolved as soon as they were informed and, when required, put measures in place to address the risks.

Staff and the registered manager had understanding about people who lacked capacity to make decisions for themselves. However some people potentially had fluctuating capacity because of their diagnosis and complex needs but the Mental Capacity Act Code of Practice had not always been followed when people's capacity was in question. People's capacity had not always been considered when decisions such as administering medicine were part of their personal care.

Staff were aware of their responsibility to protect people from avoidable harm or abuse and had received training in safeguarding. They knew what action to take if they were concerned about the safety or welfare of an individual and told us they would be confident reporting any concerns to a senior person, the provider or whom to contact externally. The provider had put a confidential phone line in place to encourage staff to report concerns. The registered manager understood when they were responsible for informing the local authority and CQC about safeguarding.

The agency made contact with other health and social care professionals to help with people's care; this was important because many people had complex needs. Staff supported and respected the choices made by people. People's cultural and religious differences were respected.

People were always informed if a member of staff was delayed and running late and they were regularly seen by the same members of staff. Staff encouraged people to be as independent as possible and provided companionship when it was required.

People and their relatives thought the staff were kind and caring and we observed positive interactions. The privacy and dignity of people was respected and people were encouraged to make choices throughout the visits we went on.

People knew how to complain and there were good systems in place to manage the complaints. The registered manager demonstrated a good understanding of how to respond to complaints and completed them in a timely manner.

The registered manager and provider had a clear vision for the agency and had some systems in place to communicate this.

We made a recommendation that the agency finds out more about national guidance in relation to the Mental Capacity Act.

We found breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the 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 agency was not always safe.

People did not always receive their medication safely. Risk assessments were not always completed so that staff had clear guidelines to follow.

People were not always supported by staff who had received checks or risk assessments on their suitability to work with vulnerable people.

Staff understood how to keep people safe and who to tell if they had concerns about people's safety.

There were enough staff to meet the needs of the people receiving visits and there were systems in place to inform people if staff were running late.

Is the service effective?

Requires Improvement

The agency was not always effective.

People were supported by staff who had not always received training to ensure they had skills and knowledge for their role. Training was delivered by a trainer who had not kept their qualification up to date.

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People's capacity was not always considered for specific decisions. The registered manager and staff demonstrated understanding about making best interest decisions on behalf of someone who did not have capacity.

People were supported appropriately to eat and drink if it was required.

People were supported to have referrals made to health and social care professionals when required.

Is the service caring?

Good

The agency was caring.

People told us that they were well looked after and we saw that the staff were caring.

People were involved in making choices about their care.

People's privacy and dignity was respected.

Is the service responsive?

Requires Improvement

The agency was not always responsive

People had care plans which were individualised and captured their voice. However, at times there were a number of different versions which meant staff would not know which was the most recent.

If people's needs became different the care plans were not always up to date with these changes.

People received care and support in line with care plans and staff were familiar with them.

People knew how to make complaints and there was a complaints system in place.

Is the service well-led?

Requires Improvement

The service was not always well-led.

The service had informal quality assurance systems in place but they did not identify some of the shortfalls we found. When shortfalls we found were raised with the management team they were managed quickly and risks were mitigated.

People and staff were positive about the management of the home.

The registered manager and provider had a vision for the home and staff were well supported.

Castle Care Wessex

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 agency, and to provide a rating for the agency under the Care Act 2014.

This inspection took place in the service office on 12 and 21 April and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the registered manager would be available for the inspection. It also allowed us to arrange to visit people receiving a service in their own homes. It was carried out by an adult social care inspector.

We visited five people in their own home on 19 April but only four were able to speak with us. During the visits we met two relatives, two members of staff and a visitor. We looked at people's care plans kept at their homes. We also telephoned one person, two relatives, two members of staff and one health and social care professional. Whilst we were in the office we spoke with the registered manager and operations director.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the agency, what the agency does well and improvements they plan to make. We looked at the information in the PIR and also looked at other information we held about the home before the inspection visit. During our inspection we spoke with the registered manager in more detail about their PIR and we saw an evidence file of further information.

We spent time at the main office of the service where we reviewed three care plans, five staff personnel files, records of staff training, accident and incident file, complaints and compliments files and quality monitoring records.

Requires Improvement

Is the service safe?

Our findings

People were at risk of being cared for by unsuitable staff due to the provider not ensuring all staff had checks and risk assessments completed before working with vulnerable people. The registered manager applied for Disclosure and Barring Agency (DBS) checks and references from previous employers. DBS checks show an employer if a member of staff is safe to work with vulnerable people by checking their suitability. Staff confirmed they had checks prior to commencing their employment. However, there was evidence that a person had commenced worked without the appropriate DBS assessment in place. This had been resolved at the time of the inspection.

Another member of staff during their recruitment had concerns raised from a previous employer. The registered manager had not completed any additional checks or created a risk assessment to protect the people being supported by the staff member. Following our inspection the registered manager and operations director put together an action plan of how to protect people. They had spoken to people receiving support from the member of staff which was positive. Other actions included a risk assessment being written and speaking to the previous employer. Following the inspection the registered manager kept us up to date with actions being taken in relation to this staff member.

This is a breach in Regulation 19 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People did not always receive their medicines safely. Some people required staff to support them with managing and the administration of their medicines which was confirmed in their care plan. There was a section which informed staff of their medicine, how they were taken and consent for staff helping them. Each person who was assisted by the agency had a medication administration record chart (MAR) in their home. MAR charts were a way for staff to document each medicine a person is taking including the dose, quantity and frequency. They also allow staff to log when a person refuses their medicine or is unable to take it due to a range of circumstances.

The registered manager told us there had been no medicine errors or incidents and they checked MAR charts every month when paperwork was brought to the office. However, one person's health was put at risk because there were three mornings where seven medicines had not been administered. Their daily log recorded they had been asleep during their morning visit. The member of staff confirmed they had left the pot of medicines on the bedside table and they were gone at the next visit; no one knows whether the person had taken their prescribed medicine. In the person's care plan it was written they needed "Complete management of medicines". A member of staff and the registered manager confirmed the person had difficulty sometimes remembering to take their medicine. We found four days when their medicine had not been signed for in the MAR chart. We raised this with the registered manager; they immediately started an investigation. The registered manager contacted the person's GP and next of kin to alert them of the errors. They asked the next of kin if a complaint should be raised but this was declined. They also completed an action plan for a member of staff to provide additional support and amended the MAR chart to make it clearer for staff in the future. During the registered manager's investigation other staff members confirmed

they had given the medicine but had forgotten to sign the MAR chart.
Care plans did not always contain consistent risk assessments when required. For example, one person had recently had two falls, but their care plan said no falls risk assessment to be completed. A second person had it written in their care plan they struggled with swallowing; there was no risk assessment in place around their eating. In addition to these, some people required specific equipment to help them transfer between two surfaces such as a chair and bed. There were no detailed risk assessments in their care plans. A person explained there were some issues with new staff around moving and handling. Therefore, new staff would not always have information about the specific equipment and how it should be used. We spoke to the registered manager and the operations director who acknowledged people could be at risk. They said the new provider had some moving and handling risk assessments which would be introduced around transfers of people. They had reviewed and completed these by the third day of the inspection. For the person with falls the registered manager said they would complete a new risk assessment and update their care plan.

People were at risk because staff did not always use protective equipment to prevent the spread of infections. Staff were supplied with gloves and aprons to wear during personal care. Personal care means assistance from a staff member with daily tasks including maintaining personal hygiene such as bathing. One person said, "They [the staff] always use gloves and aprons". The registered manager told us they kept a stock of disposable gloves and aprons at the office and staff should restock when in the office. They said, "I expect staff to wear them [meaning gloves and aprons]". However, we saw a member of staff assist someone with personal care who wore gloves but no disposable apron. The staff member said they had "Never queried about aprons" and continued to explain they only had gloves from the provider. Another member of staff said they "Haven't always worn an apron" and continued to say, "We don't generally get splashed or soiled". This meant staff were not always protecting the person or themselves from infections spreading when delivering personal care.

This is a breach in Regulation 12 of the Health and Social Care Act 2010 (Regulated Activities) Regulations 2014.

People and relatives told us they felt staff provided safe care. One person when asked about staff keeping them safe said, "Excellent". Another person said, "Yes, I feel safe" when they were asked. A relative said, "[They] keep [their relative] safe" and another relative explained the actions a member of staff had taken to help keep their family member safe from falls by getting them a piece of equipment to alert others.

Staff told us, and records seen confirmed all staff received training in how to recognise and report abuse. Staff had a clear understanding of what may constitute abuse and how to report it. One member of staff told us the process of raising a concern internally and then who to go to if that was not working. Another member of staff gave a recent example of how they kept someone safe and used the agencies on call system. All were confident that any concerns reported would be fully investigated and action would be taken to make sure people were safe. Where allegations or concerns had been bought to the registered manager's attention they had worked in partnership with the new provider and relevant authorities to make sure issues were fully investigated and people were protected.

People were supported by sufficient numbers of staff to meet their needs in a relaxed and unhurried manner. One person said, "Regular staff can facilitate my needs" and another person had a care schedule showing four different staff members would visit them. All the people were happy with the staff who supported them and confirmed it was regular, small number of staff. People had copies of their visit schedule and staff would remind those who had difficulties with their memory. People told us staff were usually on time with their visits, but if they were running late there would be a phone call from the member

of staff or the office. The registered manager and provider informed us staff levels were based on detailed assessment they had completed of people; as the agency was so small they did not use more formalised methods. When staff had identified people's needs had changed which could impact upon staff levels a 'change of needs referral form' was completed.

Requires Improvement

Is the service effective?

Our findings

People were not always supported by staff who had received training to ensure they were skilled and competent. Most staff were positive about the training they had received. A staff member said, "I do lots of training – stroke, fire training. Lots of courses. I always want to learn. Have done my Diploma Level 3 [meaning a qualification in health and social care]". Another staff member told us about the training they had received including moving and handling, medication, fire safety and nutrition. One staff member said they would like Mental Capacity Act training. However, during the first day of inspection, we found one person had a specific medical condition, but no staff had received training to understand and meet this person's need. The registered manager said the person's relative was in the house during visits but had not considered if the staff members were left alone. The operations director sourced some specific training for staff who worked with this person. By the third day of the inspection all staff had received training for this health need. The operations director and registered manager explained this had triggered them to consider other specific health needs of people so sourced relevant training for staff.

All staff had received training in administering medication from the registered manager including some newly appointed staff. They had unannounced spot checks and medicine administration was part of this. But, The registered manager had not completed their train the trainer course since September 2013. The provider of the course recommended the course should be refreshed every two years to ensure the trainer was up to date with current legislation and guidance around medication administration. The registered manager explained they had not contacted the provider who delivered the training.

People's consent to care and treatment was not always sought in line with legislation. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

We checked whether the principles of the MCA were being adhered to by staff and the agency. Most staff had a good understanding of the principles of the MCA and could explain if people lacked capacity then you act in their best interest. Best interest decisions are a way for relatives or people important to them and health and social care professionals to make specific decisions on behalf of someone who lacks capacity by considering what they would choose. A member of staff correctly told us the process for when someone does not have capacity. The registered manager had created an overview handout to illustrate the MCA and important facts. They explained MCA was covered during safeguarding and dementia training, but they would look into specific MCA training for staff. However one person's care plan said, "I generally have confusion when taking tablets" and had a specific health need which would cause this. There was no MCA assessment or best interest decision in line with the guidance from the MCA Code of Practice. The registered manager agreed the person required a capacity assessment for whether they needed support with taking medicines. During the inspection they completed the MCA assessment and best interest decision for this person. When other people lacked capacity they did not have all important decisions documented in their care plans for important decisions but the registered manager completed them during the inspection. Staff

had been considering best interest without recording it correctly.

We recommend that the agency finds out more about national guidance in relation to the Mental Capacity Act.

People were supported by staff who had undergone an induction programme which gave them basic skills to care for people safely. Staff confirmed they had completed the Care Certificate. The Care Certificate is a set of minimum standards which should be covered as part of induction; this ensures health and social care workers follow them in their daily working life. Staff told us they had enjoyed completing the qualification. Staff files showed they had been completing the Care Certificate including the observations from the management. The registered manager and staff told us staff completed shadow shifts at the beginning of their induction. This meant they became familiar with how to support different people in their homes.

Staff confirmed they had all received supervision at least every three months. Supervisions are meetings held to support staff, identify training and discuss any concerns between a staff member and management. The staff explained they were asked four things they wanted to talk about and the supervisor spoke about four things. There were two types of supervision in the agency; one was planned and one was responsive. The responsive supervisions could be in relation to an issue found by the provider or when a member of staff wanted to discuss something. During staff members induction period the supervisions should be more frequent in line with the provider's policy but this had not always happened.

All people were asked at assessment prior to the agency supporting them whether they need help preparing food and with eating. This made sure people who required support received a diet in line with their needs and wishes. Staff would ask people what they would like to eat and then prepare the food. One person said they had already had breakfast but the staff provided them with another bowl of cereal; the staff member explained that sometimes the person forgot if they had eaten so they wanted to be sure they had. The person was grateful to the member of staff and ate all their cereal. Another person had lunch prepared for them. They became excited at the steak which was removed from the freezer for the next meal following a discussion with the staff member. Other people had sandwiches prepared for them and left in the fridge for later.

People had arrangements made to see health care professionals according to their individual needs. For example, one person had recently had falls so the registered manager had made contact with the person's GP to ask for a referral to a physiotherapist. A second person had an incident with a piece of equipment which helped them to transfer between an armchair and a wheel chair. One of the actions taken by the agency was to refer them to an occupational therapist that could reassess them.

Good

Is the service caring?

Our findings

People were positive about their care they received and said they were supported by kind and caring staff. When asked about the staff they said, "Couldn't wish for better girls", "They are all so very nice", "Very professional, understanding and empathic" and "The carers are very good". A relative said they provide, "Very good care" and continued to explain they were "very happy". The provider had completed a Client Satisfaction Questionnaire and comments included "They really do care and having them on board has been such a relief" and "I am very happy with the quality of care I receive".

During our inspection staff demonstrated a friendly and caring approach. We observed people were treated with respect and given choices in a way that they could understand. Staff were patient including allowing time for a person to express themselves. They respected preferences people made. One person was resistant to personal care and the member of staff respected this. After providing encouragement to see if the person would change their mind they offered to try another day.

Most people's privacy was respected and all personal care was provided in private. When the staff members entered people's homes they knew the process and always went to greet them. People responded positively to their greeting and, if they were able, communicated what they wanted to happen. During personal care the staff knew the importance to show respect and protect people's modesty. However, one person had an issue with their curtains not being able to close. As it was their own home they could make the decision but the staff member was not sure whether the person had capacity. The registered manager has liaised with the person's relatives to resolve the curtain issue and had completed a capacity assessment.

There were ways for people to express views about their care. Each person had their care needs reviewed on a regular basis which enabled them to make comments on the care they received and express their opinions. One person explained they have a regular review but felt comfortable if they wanted changes outside of that they could ask and it would be done. A relative said, "If we want something they made changes". The relative for another person explained the registered manager had recently come out to complete a review on their relative; they had just received a copy of the updated care plan to read and sign. If people were able to they read and signed their daily logs.

People told us they had regular care workers they had become attached to and knew well. During our visits people named care workers they saw every day or week and spoke highly of their care. A relative said they were happy and had a favourite carer who visited regularly. People had copies of the visits schedule and staff members spoke with them about who was coming tomorrow.

The agency kept a record of all the compliments they received. We saw if compliments were specific to an individual member of staff the message was shared with them and recorded in their staff file. We read a selection of compliments. They included comments on individual staff and thanks from relatives for looking after their loved ones during a difficult time. Some of the compliments were in the form of thank you cards.

People's differences were respected and their cultural needs respected. For example, a person with

additional sensory issues was sitting, the staff member knelt in front of them and spoke clearly so they could understand. Another staff member said they were trying to source a wheelchair so they could take a person to church during a visit. In care plans we saw a review for someone with a sensory loss complimenting the support staff were providing. Another person who had experienced a traumatic event in their life had this issue documented in a respectful way with guidance for staff on how best to support the person.

People were encouraged to maintain their independence whilst being supported to live in their own home. A person told us they were "Pretty independent". Another person was encouraged to continue to administer their own medicine to maintain independence. One staff member said, "We promote independence and support people in their own home. This is a big thing".

Requires Improvement

Is the service responsive?

Our findings

People had multiple copies of their care plans in their home and the office which could cause confusion for staff. Each person had a file in their home and the office for their care and most people had more than one care plan in each file. For these people it was not clear which care plan was the most recent version. During the visits staff said copies were sent to people's houses; we saw a person received a new copy following a review. The registered manager and operations director explained they were in the process of changing care plans and a new review sheet would be introduced to show what changes had occurred and when. In future they wanted staff to update the files in people's homes so only one care plan would be present.

People's reviews had not always identified important changes in their support. For example, one person received a reviewed care plan which had not identified a change in their mobility. During the inspection, the staff member was knowledgeable about these changes so raised it immediately with the registered manager. The necessary changes were made to the care plan including a risk assessment.

People said staff had a good knowledge of their care needs and responded in a flexible way to any changes which were identified. One person explained that the staff who had been with the provider the longest knew their needs. Another person said, "I have the same one [care staff] most of the time so they get to know the routine". A relative explained a member of staff looked after their relative whilst they went on holiday because they knew the person's needs. Other relatives confirmed staff knew their relative's needs well. A member of staff said, "Observations I do have triggered care reviews" and another one told us they regularly went to the office to discuss people's needs.

Care plans were personalised to each individual and contained information to assist staff to provide care in a manner that respected their wishes. They captured the person's voice and informed staff about people's preferences. For example, one care plan said, "I would like my carer to check if I have had my lunch and if not would like them to make me a cheese sandwich". Another person's care plan described how they like food served "Place on a small rectangular tray (with flowers on) and cover with cling film".

Each care plan contained a Kitwood's Flower in it with important details about that person. Kitwood Flowers were originally created to put the person at the centre of their care by focussing on psychological rather than medical needs. Areas covered on the outside of these diagrams were comfort, inclusion, attachment, identity and occupation. All the outer suggestions led to improved well-being in the centre. For example, one person's Kitwood Flower mentioned their charity voluntary work and others mentioned important people in their life. This provided staff with additional information to understand the person and helped them provide care and companionship during the visits.

People's needs had been assessed before the agency supported them. This meant people's needs would be met and staffing was appropriate. Staff told us they were sent new people's details prior to starting working with people. They said this helped them know about them and their needs were understood.

Each person had a daily record of every visit. If people were able, they read and signed their daily logs to

show they had agreed with what had been written. People said they knew about their care plans and had been involved in deciding how their care and support would be provided. Every month the daily records were returned to the office so management could identify issues or changes and could monitor the visits.

The registered manager sought people's feedback and took action to address issues raised. People and staff explained that the management were responsive to suggestions and changes required. Staff said there were not regular staff meetings but the registered manager had identified this and wanted to increase the amount of them. They wanted to have a theme of the month for each of them. It was also so information could be shared.

There had been a 'clients' satisfaction survey completed by people who use the service. The results had been positive and the provider shared the completed analysis. Most people 'strongly agreed' or 'agreed' with every question asked. For example, a question about their care plans being tailor made to meet people's needs had 48 percent strongly agreeing and 48 percent agreeing with the statement. The operations director and registered manager expressed how pleased they were and would make any required improvements.

People said they felt they could complain if they needed to and the agency responded to their concerns. One person told us the complaints practice was "Part of the review process". Another person explained they would "Ring the office" and confirmed they had seen the complaints procedure. A relative described a miscommunication which had occurred and confirmed it was resolved quickly by the registered manager.

We looked at the complaints records kept by the registered manager. There was clear documentation to show a complaint or concern had been received and how it had been managed. All complaints had been dealt with promptly and included outcomes for the person as well as a record of learning. One person had been so happy with the handling of their complaint they gave the registered manager a box of chocolates.

Requires Improvement

Is the service well-led?

Our findings

There was not an effective quality assurance system in place to monitor the care being delivered and plan ongoing improvements. Some quality assurance systems were informal. For example, staff brought paperwork from people's houses for the registered manager to see and the registered manager would regularly speak with people and staff. However there was no documented record of this and any actions taken. The systems currently in place had not identified shortfalls we found on inspection such as risk assessments, medicine administration and concerns around people's capacity. The registered manager explained they had not created a whole service action plan but during the inspection this was created. Therefore, despite not finding the deficits they responded promptly and proactively to rectify them.

In August 2015, the company had been sold to a new provider. Since the sale the operations director had been supporting the registered manager. There had been monthly managers meetings for the registered manager to attend and receive peer support. A care consultant had visited to begin reviewing systems being used. However, there had been no whole service internal audit to review quality assurances systems and provide the registered manager with additional monitoring of the care arrangements. The operations director was aware of some areas of improvement such as reviewing care plans, but there was no action plan in place that confirmed timescales for improvement. The operations director told us an internal audit was planned for May 2016 and they would continue to meet with the registered manager on a fortnightly basis.

More formal quality assurance systems were emerging and the registered manager was being supported by the new provider. Where shortfalls in the agency had been identified action had been taken to improve practice. For example, the operations director explained the provider was introducing a new electronic system to create the rotas and log information about people. It was felt this would make the service more streamlined and when things were due such as care plan reviews it would alert the registered manager.

People and staff were positive about the registered manager. The people we spoke with said the registered manager was approachable. One said, "[The registered manager] is very professional, understanding and empathetic". A member of staff said, "I feel I can trust them. They are honest". Another said, "[The registered manager's name] is supportive" then continued "[The registered manager's name] is not frightened to get their hands dirty".

The registered manager had a clear vision for the agency to provide high quality care to people in their own homes. Their vision and values were communicated to staff through informal chats, the induction and training and formal one to one supervisions. Supervisions were an opportunity for staff to spend time with a more senior member of staff to discuss their work and highlight any training or development needs. They were also a chance for any poor practice or concerns to be addressed in a confidential manner. To support the supervisions members of the management completed spot checks of staff providing care to people in their homes. These were unannounced and provided the management with information about the quality of care being delivered and whether best practice was being followed. It highlighted if there were any areas of development for the members of staff.

There was a staffing structure in the agency which provided clear lines of accountability and responsibility. Castle Care Wessex is part of Berkeley Home Health which is a larger organisation with different locations. There is an operations director and peers in place to support the registered manager in the agency. There were also specialist provisions such as human resources available to support specific functions of the service. In the agency there was a clear staff structure and work was being taken to develop a member of staff into a deputy manager. The staff said they were confident of people's roles as they knew who to talk to and who would support them with supervisions appraisals and training needs. Staff knew they could go to the operations director if the registered manager was not available. The provider had recently introduced a confidential telephone number staff could call if they suspected abuse but did not want to speak with the registered manager or operations director.

All known accidents and incidents which occurred in the agency were recorded and analysed. There was a section where lessons could be learnt were recorded. If it had been decided further action was required we could see this had been completed. For example, one incident involved an issue with moving and handling so a referral to a specific health and social care professional was made. In another case to prevent trips some environmental changes had been made in the person's home. Incidents which had been found during the inspection were investigated thoroughly. When the registered manager had decided further actions to mitigate risks were required they had put this in place.

The agency had notified the Care Quality Commission of all significant events which have occurred in line with their legal responsibilities. They had also made referrals to the local authority when appropriate such as for safeguarding. This meant they were informing external parties of occasions required so the safety and quality of the agency could be monitored.

People and staff were supported to share their views of the way the agency was run. The registered manager explained they were always open to people talking to them. One staff member said, "I have suggested things and they [meaning the registered manager] will look into things". They said there had not been as many staff meetings as there should have been but were in the process of changing this. There were plans to have themes so staff could learn and discuss specific topics such as safeguarding. An annual survey of people, relatives and staff was carried out so people could be assured that improvements were driven by their comments and experiences. We saw the results of the latest survey completed by people and their relatives which were very positive about the care and support being provided.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not ensuring there was proper and safe management of medicines, risk assessments were not always in place and protective equipment was not always used to prevent infections spreading. Regulation 12 (1) (2)(a)(g)(h)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Recruitment procedures had not made sure people employed had the correct checks prior to working. Regulation 19 (3)(a)