All Care (GB) Limited

All Care - West Berkshire

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

Summary of findings

Overall summary

About the service
All Care – West Berkshire is a community care provider providing personal care to 49 adults at the time of the inspection. This included people living with sensory impairments, physical disabilities and dementia. The service employed 27 staff which included 19 care workers.

Not everyone who used the service received personal care. CQC only inspects where people receive personal care. This is help with tasks related to personal hygiene and eating. Where they do, we also consider any wider social care provided.

People's experience of using this service and what we found
There were not always sufficient suitably qualified and experienced staff deployed to safely meet people's needs. Calls were late, shortened, missed or cancelled as a result. Both people and relatives expressed their dissatisfaction with the completion of their commissioned calls. Although some incident and accidents were recorded, many were not recorded at the time they occurred. Adults at risk of abuse or discrimination were protected from such harm by the service. Staff and the service took appropriate steps to protect people from the risk of infections, such as COVID-19.

Not all staff training was up to date. As staff had covered vacant shifts and worked some long hours, they did not have time to complete or refresh their statutory and mandatory training. People and relatives stated regular care workers knew their preferences and how they liked to be supported. However, they stated that regular changes in staff without notice meant that staff did not always know how to best support them. There were appropriate risk assessments in place related to people's support packages.

There was mixed feedback from people and relatives about how caring the service was. However, most praised the regular care workers that supported them. They commented that they were kind and provided support in the right way. People and relatives were involved in care planning. People's privacy and dignity was protected.

Care plans contained the necessary information to support people. They included how care should be planned, delivered and evaluated. There was a satisfactory complaints system in place.

The governance of the service was not always effective. Failure to continuously monitor increasing burden from people's packages of care meant that personal care calls started to be rushed, missed, late or cancelled. Although people and relatives had contacted the service to complaint, they reported difficulty reaching staff by phone. Some people had resorted to ringing care workers on their own mobile phones to check whether they would receive their care. During a large staff absence on a weekend, the business continuity plan was implemented. Whilst steps were taken to meet complex care packages, other people's care was cancelled, and relatives were asked to provide support instead. This led to frustration amongst some people and relatives involved, and a loss of trust and confidence in the service. The service worked

with the local authority to ensure that people's care needs were being met. The local authority had contacted people to ensure calls were being completed. The local authority confirmed to us after the inspection that calls were being carried out in accordance with the commissioned care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible and in their best interests; the policies and systems in the service supported this practice.

For more details, please see the full report which is on the CQC website at www.cqc.org.uk

Rating at last inspection
This service was registered with us on 28 August 2020 and this is the first inspection.

Why we inspected
The inspection was prompted in part due to concerns received about staffing shortages and alleged poor communication from the service with people and relatives. A decision was made for us to inspect and examine those risks.

We have found evidence that the provider needs to make improvements. Please see the Safe, Effective and Well-Led sections of this full report.

You can see what action we have asked the provider to take at the end of this full report.

Follow up
We will request an action plan for the provider to understand what they will do to improve the standards of quality and safety. We will work alongside the provider and local authority to monitor progress. We will return to visit as per our re-inspection programme. If we receive any concerning information we may inspect sooner.

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.

Details are in our safe findings below.

Is the service effective?

Requires Improvement

The service was not always effective.

Details are in our effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our responsive findings below.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Details are in our well-led findings below.

All Care - West Berkshire

Detailed findings

Background to this inspection

The inspection
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) as part of our regulatory functions. We checked whether the provider was meeting the legal requirements and regulations associated with the Act. We looked at the overall quality of the service and provided a rating for the service under the Care Act 2014.

Inspection team
The inspection was carried out by two inspectors and two Experts by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type
This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats.

The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection
This inspection was unannounced. Inspection activity started on 24 May 2021 and ended on 28 May 2021. We visited the office location on 24 May 2021.

What we did before the inspection
We spoke with members of the public who had already raised concerns with us. We reviewed information we held and had received about the service since its registration. We sought feedback from the local authority, safeguarding team and other professionals who work with the service.
We checked information held by Companies House and the Information Commissioner's Office. We checked online reviews and relevant social media. The provider was not asked to complete a provider information return prior to this inspection. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report. We used all this

information to plan our inspection.

During the inspection
We spoke with eight people who use the service and thirteen relatives about their experience of the care provided. We spoke with the nominated individual. The nominated individual is responsible for supervising the management of the service on behalf of the provider. We spoke with the operations manager, registered manager, two care supervisors and two care workers.

We reviewed a range of records. This included four people's care records and medicines administration records. We looked at five staff files in relation to recruitment and staff supervision. A variety of records relating to the management of the service, including policies and procedures were reviewed.

After the inspection
We continued to seek clarification from the provider to validate evidence found. After the site visit, we requested and received further information from the registered manager about the service's governance and training. Some staff contacted us to provide further information.

Requires Improvement

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant some aspects of the service were not always safe and there was limited assurance about safety. There was an increased risk that people could be harmed.

Staffing and recruitment

- There were insufficient numbers of suitably qualified, competent, skilled and experienced staff deployed to safely meet people's needs.
- Prior to the inspection, members of public contacted us to report missed and cancelled personal care calls, late calls, calls which did not meet the duration set out in the care plan and family members having to provide personal care instead.
- We checked with both the local authority and provider regarding the staffing levels before the site visit. The local authority made their own contact with people and relatives. In total 31 calls were made by the local authority. Feedback included that care calls were sometimes late, missed or cancelled.
- The provider sent us information about missed calls pertaining to one weekend commencing 8 May 2021. This was due to unexpected high staff absences. It showed the calls that were cancelled. The provider said they disputed some of the feedback the local authority provided and had completed an investigation into each allegation from people and their families.
- The registered manager agreed that some of the local authorities findings were accurate. The local authority told us they would temporarily suspend any new packages of care with the service.
- At the inspection, we found that there were missed and late calls prior to and including the weekend of staff absences. There was also instances where one care worker attended care calls despite some people requiring two care workers for support.
- People and relatives repeatedly told us that there were staff shortages and as a result, their support was sometimes compromised. They also reported that they were not always told about changes to their calls, which care workers were attending and sometimes could not reach the office by phone to enquire about their support.
- People commented, "At the moment they're a bit short [of staff]…they come in at different times…. sometimes they clash", "It's very rare they're on time; they're always late….can be from 15 minutes late to as late as midday. They give me the name of the carer and it's not that person who turns up" and "They're [messing] me about. I ring the office, they're very lax….it's [very] frightening."
- Relatives stated, "Recently there have been a lot of temporary carers. The visits should be 30 minutes but have been as short as four minutes...this has been ongoing since September (and October) last year", "(The person) has four visits a day…with two carers; sometimes [the service] only sends one [care worker]", "They were two hours late yesterday and one and a half hours today. They (care workers) rarely stay as long as they should…20 minutes yesterday when it should be 45" and "Timings are amiss. They have been late recently which causes stress. They never tell us they will be late. It has got worse in the last six months."
- Staff stated, "(There is an) unsafe working environment for carers…working over 15 hours (per) shift

without breaks. 'Double up' calls (are) being done by a single carer, putting (the) carer and client at serious risk."
● Staff personnel files contained the necessary checks and documents to ensure only 'fit and proper' persons were employed.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Learning lessons when things go wrong
● Incidents and accidents were not always recorded.
● The incident folder showed that few of the missed, late or cancelled calls were logged. When we asked the registered manager, they confirmed these had not been logged for the weekend of high staff absences. However, missed, late and cancelled calls were experienced by people prior to this date.
● The registered manager wrote to us after the site visit to confirm all late and missed calls were since logged. The explained how information was shared with the provider's management team via weekly reports.

Systems and processes to safeguard people from the risk of abuse
● People at risk were protected from abuse and discrimination.
● There was an appropriate safeguarding policy in place which explained what steps to take if there was any allegations of abuse.
● The service reported allegations to the local authority as required. The local authority confirmed that the registered manager worked with them during any enquiries or investigations.
● The service informed the CQC of any allegations using the required notification forms. They provided additional information to support steps they took to protect people.

Assessing risk, safety monitoring and management
● People's risks were assessed prior to commencement of their package of care.
● Information was gathered from commissioners, social workers, the person and their families (if relevant). Staff used this to formulate the risk assessments.
● Risk assessments were updated with additional information as more details became available. For example, if care workers found differences in the planned care to the actual care delivered, they informed the office staff so the risk assessments could be updated accordingly.
● Risk assessments included the person's home environment, moving and handling, risk of skin damage and nutrition.

Using medicines safely
● People's medicines were not always safely managed.
● Some people had missed their medicines due to insufficient staff deployed. This meant they were at risk from not having their medicines administered as prescribed.
● Staff completed both computer-based and practical training, observation and competency assessments prior to supporting people with their medicines.
● Satisfactory records of medicines were completed.
● Medicines incidents were correctly reported. Care workers called the office with information about any errors, and an incident form was used to record the details. The registered manager reviewed the content.

Preventing and controlling infection
● People were protected against the risk of infections. They told us staff used personal protective

equipment (PPE) when they received support.

● For example they said, "They (staff) do have masks, aprons, gloves and dispose of gloves", "They (staff) wear masks, aprons and gloves…change outside and dispose of stuff in the bin" and "They (staff) wear masks, gloves and aprons."

● The service supplied staff with appropriate PPE. This included disposable gloves, aprons, eyewear or visors and masks. The service ensured enough PPE was available throughout the pandemic.

● Staff maintained hand hygiene by washing their hands or using alcohol-based gel which they carried with them.

● The service ensured they followed government guidelines regarding the COVID-19 pandemic. This included how to keep people safe, and how to work safely as a care worker.

● Staff completed regular testing for COVID-19 as part of the national programme, to ensure they were safe to work with people. The registered manager showed us the record of staff test results.

● We have also signposted the provider to resources to develop their approach.

Requires Improvement

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the effectiveness of people's care, treatment and support did not always achieve good outcomes or was inconsistent.

Staff support: induction, training, skills and experience

- Staff did not always have the training, assessment and supervision necessary to ensure they knew how to perform their role.
- The training record showed training was overdue for some staff, including training in safeguarding and moving and handling. The registered manager told us they were in the process of supporting staff to update their training.
- We reviewed staff training documentation and it was identified some staff training was not up to date, for example two members of staff had not received training since November 2019 and another had received any training since January 2020.
- The service had not implemented a system to identify when staff training was next due. This was discussed with the registered manager who reported that this was to be implemented in the future.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

- Staff received an induction that included shadowing experienced staff to learn about their role in supporting each person and completing care duties effectively and safely. All new staff also completed the Care Certificate, which is a set of nationally agreed training modules for staff working in adult social care.
- Staff received monthly supervision either face to face or via telephone contact. The service held detailed records of the discussion and included actions from previous supervisions.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law

- People and relatives felt the regular staff knew their preferences, but commented that continuity of care workers meant they sometimes were not aware of the way they liked their support.
- One person said, "The majority of them are pretty good. There are two carers I really; they know what I like and don't like. The new ones always need help. I've got my favourites
- Relatives stated, "Yes they always ask if she (the person) is happy to have her care", "She (the person) likes at least one female carer, but sometimes two male carers arrive", "Because there are so many (care workers), they don't know likes and dislikes. The regular ones do", "I think so, but there is a large turnover of staff. Different ones come all the time", "I believe they (care workers) did when there was some consistency of carers" and "They know what she likes; one carer speaks German to her, which she likes.'
- Care plans were individualised and contained information identifying peoples likes and dislikes and a summary of daily routines, including how the person wanted their care to be carried out.

● Daily notes of people's care were satisfactory and included documenting people's emotional wellbeing at each visit.
● People's needs, and support plans were reviewed on an annual basis for any changes in care and support, or more often if their needs changed.

Supporting people to eat and drink enough to maintain a balanced diet
● Risk assessments relating to people's nutrition requires were documented in people's care plan to ensure staff were able to meet their needs
● Documentation within daily records included the food and drink provided at each visit in order to monitor people's nutritional intake.
● The level of support with eating and drinking required was also included. One care plan said, "I would like my care worker to remind me to have a drink or a meal when they are on a visit."

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
● The service was in regular contact with local authorities who support with funding for people using the service in order to continue to meet the needs of the person.
● The service regularly worked with occupational therapists and district nurses to ensure people had the support they needed. Any changes to people's care from reviews with professionals was documented within the care plan.

Ensuring consent to care and treatment in line with law and guidance
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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

When people receive care and treatment in their own homes an application must be made to the Court of Protection for them to authorise people to be deprived of their liberty. We checked whether the service was working within the principles of the MCA.

● People's care plans contained records of their capacity to make decisions about their care and support.
● If a person had a lasting power of attorney in place, evidence of this had been sought and included within the person's documentation. One care plan stated, "[The person] has capacity to make decisions regarding their personal care on a day to day basis."
● During this inspection we saw that people's care records provided staff with detailed information in respect of the decisions people were able to make independently.
● All staff had received training regarding the principles set out in the MCA.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; respecting equality and diversity
- When asked how caring the service was, people's and relatives comments again included the issues of missed or late personal care calls.
- There was mixed feedback about how caring the service was. People had differing feedback about care workers and the office staff.
- For example, people said, "[Some staff] are rude, ignorant and a bit lazy. There's good and bad and some are rubbish. It's about half and half", "The carers are pretty good. It's the office that [messes] about. They don't really care or understand. Most of the carers are good but some have got no idea" and "We have some very, very nice carers, but they are totally frustrated [by the company]."
- Relatives provided similar feedback. They said, "Their attitude to mum is good", "They are very kind and sweet", "They treat [the person] nicely; they are good at that" and "Some (staff) are very good, but others don't seem interested."
- There were some acts of sincere care provided by care workers. A relative stated, "When she (care worker) noticed that [the person] was having trouble with central heating, she actually went to her own home. and brought back a personal heater, which was extraordinarily kind."
- Another relative told us how a care worker went out of their way to ensure a person's comfort. They commented, "They are caring. I can tell they have got to know her (the person). When she fell, I found them (the care worker) sitting on the floor holding her hand. It was a genuine gesture."
- Care workers had helped people celebrate their birthdays by taking cakes to them during their visits. They were provided cards and with consent, had their photo taken with the cake as a memento.

Supporting people to express their views and be involved in making decisions about their care
- Risk assessments and care plans reflected people's involvement in decision-making about the package of care. There were also examples of relatives' involvement in care planning.
- People confirmed their participation in development of their support packages. One said, "At the beginning, we didn't have a care plan. But we have one now."
- Relatives confirmed this. Comments included, "Yes, [care planning] was done [with] social services. They then approached firms to provide the care", "Yes [care planning] was with this company" and "Yes, and I've been involved in updating it (the care plan)."
- People were able to make choices about everyday care, such as meals prepared and clothes they would wear. A relative stated, "Yes, they (care workers) look after him. They're not always chatty, but they make him a cup of tea."

Respecting and promoting people's privacy, dignity and independence

● Care workers usually respected people's abilities to complete personal care if they were able to participate.
● However, there were instances where care was performed by family members instead of care workers. One said they were "…taken advantage of…" to complete the personal care instead because the care worker was busy.
● Feedback indicated people's privacy and dignity was protected during the provision of personal care. Comments included, "Yes, they do they keep her (the person) covered and keep her warm. They take care when dressing her", "They are very good and respectful", "Yes they always close the curtains when they are with her (the person)."

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs.

This is the first inspection for this newly registered service. This key question has been rated good. This meant people's needs were met through good organisation and delivery.

Planning personalised care to ensure people have choice and control and to meet their needs and preferences

- People's care plans described their abilities, likes, dislikes and support needed. This provided staff with information and guidance on each person, so they could continue to meet their specific needs.
- People's needs, and support plans were reviewed on an annual basis for any changes in care and support or more often if their needs changed.
- Any changes to people's care was updated on their care plan and staff were notified via the communication page flags.

Meeting people's communication needs

Since 2016 onwards all organisations that provide publicly funded adult social care are legally required to follow the Accessible Information Standard (AIS). The standard was introduced to make sure people are given information in a way they can understand. The standard applies to all people with a disability, impairment or sensory loss and in some circumstances to their carers.

- The service identified people's information and communication needs by assessing them and recording this in their care plans.
- Within people's care plans, there was guidance in place for staff to communicate with people in a manner they could understand.

Improving care quality in response to complaints or concerns

- There was an appropriate complaints system in place.
- Complaints had been recorded and the registered manager responded to complaints in a timely way.
- There was evidence recorded and provided to show how the provider acknowledged, investigated and responded to complaints.
- Actions taken following a complaint were documented in order to improve the service.

Requires Improvement

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

This is the first inspection for this newly registered service. This key question has been rated requires improvement. This meant the service management and leadership was inconsistent. Leaders and the culture they created did not always support the delivery of high-quality, person-centred care.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements

- The service did not always provide the quality care people and relatives expected. Although systems and process for governance were in place, these were not always effective.
- All services are required to have an up to date statement of purpose. The statement of purpose did not contain all of the necessary information required by the regulation. A statement of purpose lists aims and objectives, contact details for the service and registered manager. We informed the nominated individual who sent as updated version.
- There was a business contingency plan dated January 2021. This covered a range of issues that may occur in the operation of the service, such as power loss, disruption to information technology and extreme weather events.
- The document listed the risks of staffing shortages was a low likelihood with a high impact. Timeframes were listed alongside the effects on the service, such as rescheduling calls.
- There was a lack of clarity about steps that would be taken in the event of a large staff absence. For example, within the first 24 hours of such an event the plan stated "Robust and continuous recruitment" as an action. This was not a suitable step as an immediate response to people failing to receive their care on time.
- The contingency plan did not list who was responsible for each stage of the recovery process. In addition, it did not list how success in managing each timeframe during such an event would be measured. Contact with people and relatives to advise of potential disruption was also not listed as an essential task.
- During the large staff absence event, the service implemented a red, amber and green process ('RAG' rating). This showed people who could be supported by relatives and people whose care was critical. However, the contingency plan did not list this as a step to be used in a staffing shortage.
- To manage the staffing shortage, care staff from another location were brought in after 48 hours. The 'RAG' rating system for people's care was ceased and calls were considered back to a safe level after five days.
- The service failed to notify system partners in a timely way. They had e-mailed the local authority commissioning team on a weekend, when staff in those roles are not working. This meant the local authority was not aware of the staffing shortage until after the weekend. The local authority has an emergency duty team; however, the service did not contact them to alert them of the staff shortage.
- The service did not alert the CQC to the staffing shortage which impacted care delivery for more than 24 hours. We prompted the registered manager to send the required notification, which we received one week after the staff shortage.

● Support from another location's registered manager and the operations manager was provided to the service in order to restore the continuity of people's care. An action plan was created later with responsibilities for management and a weekly analysis of steps completed
● Between the start date and end date of the inspection, the registered manager resigned without notice. They had not indicated their reason for resigning suddenly to the provider. We spoke with them after the inspection. They told us their position was untenable, and that they "…could not balance being out delivering care (due to staff shortages) with the additional responsibility of being the registered manager..."
● The nominated individual stated in the absence of the registered manager, they provided prompt cover as an experienced staff member from another location took over the service's management. They intended to register with the CQC as a manager.
● There were audits and checks of the service in place by the provider. These included weekly reporting from the service to the senior managers. However, this did not include important information such as numbers of safeguarding, incidents, missed or late calls.

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

Promoting a positive culture that is person-centred, open, inclusive and empowering, which achieves good outcomes for people
● Some people and relatives had complained about the quality of the service and care. They indicated they weren't always listened to and sometimes there was no response from the office. Some had contacted the commissioners for support with their concerns about the organisation of care.
● Comments included, "We put a long message on the app (care documentation system) about what was wrong (with the support) but it disappeared; now I send emails. They don't always get any response", "My daughter has complained about how late they come but got nowhere", "I've spoken directly to social services". "When times of visits were very close together, I spoke to All Care but nothing changed so I went to social services and there were some changes" and "We have asked women carers but they still often send a male one."
● Staff were also concerned about the quality performance of the service. One stated, "[Some] office staff… and some carers left with immediate effect due, to lack of support from senior management and the clients being put at risk. [There are safeguardings being raised by clients and local authority.]
● Staff responsibilities were not always clear, and their quality and performance required improved monitoring. Although the service had an electronic care system, the information from it was not used effectively.
● A compliance consultant completed a routine review of the service on 11 May and 12 May 2021. Their report stated, "Weekly reports are completed in line with areas of the service that are audited. However, staff need to be more aware of what the challenges are via discussions in staff meetings, the importance of adhering to time critical calls for example and the effects this has on the service, impact on family, service user and service reputation."
● Most people were able to express their preferences for male or female care workers and confirmed the service met their preferences most times. However, one person stated, "I don't mind having men (male care workers) as long as they're in doubles. I don't want men as singles. They (the service) don't always listen and there was an episode a couple of weeks ago when they sent a man, so I didn't have any care that time…"

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics
● People and relatives we contacted were concerned about the lack of response from the service when they attempted contact with the office.

● Prior to the site visit, members of the public stated at times that the phone was not answered.
● When we spoke with people and relatives, they also commented about issues contacting the service.
● One person told us they often phoned the office and always ended up leaving messages, asking for a return call. They said the office was always busy and they rarely returned calls, although a recent call to the office was responded to at 6.30pm.
● Relatives commented, "They are hard to get hold of; the phone number doesn't seem to go anywhere you have to leave a message…but there doesn't seem anybody in the office", "They don't always answer the phone when you ring", "I've phoned the office but they often don't answer I have complained but nothing has changed", "Sometimes they don't answer."
● There was a quality survey of people completed in July each year. The 2020 results showed just five people responded. There was no evidence the service contacted people (or relatives) in an attempt to gain further responses.
● There were mixed comments in the survey. For example, ""Could the carers have more travelling time? I feel they are in a hurry, so I don't get the full half hour" and "[I am] extremely pleased with all the care I am receiving from the office and care staff."
● Staff meetings were held periodically. Topics discussed at the May 2021 meeting included call times, complaints, staff communication, professional boundaries and professional behaviours. The meeting also reflected on two recent safeguarding referrals and actions taken.
● Staff surveys were also used to gather feedback. The last survey results from December 2020 showed positive feedback from 10 employees.
● Comments included, "If I ever call the office, they will always do their best to resolve problems. They are also very supportive of any personal appointments", "If I am unhappy or become stuck I feel comfortable to pick up the phone and ring the required person", "They are always helpful if I have a problem", "My registered manager will always help with a problem, is easy to get hold of and will always support with any problems. [They are] always very helpful, deals with issues immediately and gets back to you quickly" and "[The registered manager] listens when I have a complaint."

Continuous learning and improving care
● Incidents were not analysed to gather trends or themes in the event type.
● This meant the service did not have a record of the most frequent incidents for people and no plan was formulated to prevent recurrence.
● The registered manager wrote to us after the inspection and provided a list of actions the service would take to analyse and understand incidents and accidents. They stated, "Depending on the outcomes of the investigations, if [this was] human error this would lead to [one to one] supervisions with staff, and further appropriate actions if required.
● Staff car accidents whilst driving between care calls were well documented and contained supporting documentation.

How the provider understands and acts on the duty of candour, which is their legal responsibility to be open and honest with people when something goes wrong
● The registered manager was knowledgeable about the duty of candour requirements for serious injuries. There had been no serious injuries since registration and therefore they did not need to report to us or implement duty of candour as a result.
● The operations manager and nominated individual were open in their approach. They provided information to us at the site visit and afterwards to support the inspection.

Working in partnership with others
● The service worked together with the commissioners, safeguarding team and other healthcare

professionals.

● Two care workers received awards for the successful first aid they implemented for a person who had collapsed in their house.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance How the regulation was not being met: The registered person failed to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services). The registered person failed to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The registered person failed to deploy sufficient numbers of suitably qualified, competent, skilled and experienced persons to meet service users' needs. The registered person failed to ensure persons employed by the service provider in the provision of a regulated activity received such appropriate support, training, professional development, supervision and appraisal as was necessary to enable them to carry out the duties they were employed to perform.