Elizabeth Homecare Limited

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Inspection report

16 Carlisle Street
Goole
East Yorkshire
DN14 5DU
Tel: 01405 761800
Website: www.elizabethhomecare.co.uk

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Ratings

Overall rating for this service	Good
Is the service safe?	Good
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires improvement

Overall summary

This inspection took place on 23, 27 and 28 September 2015 and was announced. We previously visited the service in April 2013 and we found that the registered provider met the regulations we assessed.

The service is registered to provide personal care and other types of support to people living in their own homes, such as assisting with the administration and the preparation of meals. The agency office is located in Goole, in the East Riding of Yorkshire and staff provide a service to people living in Goole and the surrounding villages. The agency also provided an intermediate care service that was designed to help people regain their independence.

The registered provider is required to have a registered manager in post and on the day of the inspection there was a manager in post who was registered with the Care Quality Commission (CQC). A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered

Summary of findings

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 that they felt safe whilst they were receiving a service from staff working for Elizabeth Homecare Limited. People who required assistance with the preparation of meals and drinks told us they were happy with the support they received.

We found that people were protected from the risks of harm or abuse because the registered provider had effective systems in place to manage any safeguarding issues. Staff were trained in safeguarding adults from abuse and understood their responsibilities in respect of protecting people from the risk of harm.

Staff confirmed that they received induction training when they were new in post and told us that they were happy with the training provided for them. The training records evidenced that all staff had completed induction training and that all staff had completed training on the administration of medication and moving and handling. Some staff had also achieved a National Vocational Qualification (NVQ) at Level 2 or 3.

New staff had been employed following the agency's recruitment and selection policies and this ensured that only people considered suitable to work with vulnerable people had been employed.

We saw that there were sufficient numbers of staff employed to meet people's individual needs, although there were some issues with the deployment of staff and in the lack of travelling time allowed between calls. This had resulted in staff hurrying from call to call meaning some people received less time than they had been allocated.

People told us that staff were caring, pleasant and helpful and that the support they received enabled them to remain living in their own home. However, some people expressed concerns about the efficiency of the agency's office staff.

There were systems in place to seek feedback from people who received a service. Feedback had been analysed to identify any improvements that needed to be made. Complaints received by the agency had been investigated appropriately although we noted that some were recorded as notes in people's care records rather than in a complaints log.

The quality audits undertaken by the registered provider were designed to identify any areas that needed to improve in respect of people's care and welfare. We saw that, on occasions, incidents that had occurred had been used as a learning opportunity for staff.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?
The service is safe.

People told us that they were satisfied with the assistance they received with the administration of medication.

Staff displayed a good understanding of the different types of abuse and were able to explain the action they would take if they had any concerns. Risk assessments completed in respect of people's homes protected staff and people who received a service from the risk of harm.

Recruitment practices were robust and ensured only those people considered suitable to work with vulnerable people were employed.

Good

Is the service effective?
The service is effective.

Records showed that staff completed training that equipped them with the skills they needed to carry out their role, and that they had regular supervision meetings with a manager.

People told us that they were happy with the support they received with the preparation of meals.

Staff supported people to have access to health care professionals when required.

Good

Is the service caring?
The service is caring.

People told us that care workers genuinely cared about them.

Staff respected people's privacy and dignity.

People told us that they were supported by staff to retain their independence.

Good

Is the service responsive?
The service is responsive to people's needs.

People's needs were assessed and continually reviewed and this meant that staff received information about a person's current care needs.

People's individual preferences and wishes for care were recorded and these were known and followed by staff.

There was a complaints procedure in place and people told us that they were confident that any comments or complaints they made would be listened to.

Good

Summary of findings

Is the service well-led?

The service is not always well-led.

People who used the service and others told us that office staff were very pleasant but disorganised.

Some people told us that they received a service from a regular group of care workers and that they appreciated this consistency, but other people told us they received support from too many different care workers.

There were opportunities for people who used the service and staff to express their views about the service they received.

Requires improvement

Elizabeth Homecare Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection 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 23 September 2015 and home visits to people who received a service took place on 28 and 29 September 2015. The inspection was announced; the provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the agency office who could assist us with the inspection.

Before this inspection we reviewed the information we held about the service, such as notifications we had received from the registered provider and information we had received from the local authority who commissioned a service from the agency. The provider also submitted a provider information return (PIR) prior to the inspection as requested; this is a document that the registered provider can use to record information to evidence how they are meeting the regulations and the needs of people who use the service.

Prior to the inspection we also sent out questionnaires to people who used the service. Four responses were received and the collated information has been included in this report.

On the day of the inspection we spoke with the registered providers, the registered manager, two office staff and a care worker. Following the day of the inspection we visited three people in their own homes and telephoned a further twelve people to ask them for their opinion about the service they were receiving. We also spoke with five care workers and a health care professional.

At the agency office we spent time looking at records, which included the care records for four people who received a service from the agency, the recruitment and training records for three members of staff and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us that they felt safe whilst agency staff were in their home. Comments included, “Yes, absolutely safe. I could not do without them. I have never had a minute’s concern about them coming here”, “I feel very safe with the carers helping me. I have never had a problem with any of them” and “Yes I do feel safe when they come. I know if I fell I feel confident they would know what to do to help me.”

We checked the care plans for four people who used the service and saw they contained a hazard identification form that assessed the safety of the person’s home environment. This document also included information for staff on how to reduce any identified risks. In addition to this, we saw that people had individual risk assessments in place in respect of their care needs, such as diabetes or catheter care. The risk assessments recorded the risks involved when staff carried out these tasks and how they could be alleviated.

Care plans described how people mobilised, identified equipment that was needed to safely assist people with moving and handling, and also recorded whether one or two members of staff were required to carry out these tasks safely. We saw that this information was very detailed to the extent of advising staff where on the person’s body they should place their hands to carry out safe transfers. The people who we spoke with confirmed that, when care plans recorded that two staff were required to assist with moving and handling, two staff always attended. The training record we saw evidenced that all staff had completed training on moving and handling; this meant they had the knowledge needed to carry out safe transfers.

The registered provider told us that staff received information about safeguarding adults from abuse during their induction training. We checked the overall training record and this showed that all staff had completed induction training. We checked the personnel records for three new members of staff and these showed that they had received information about safeguarding adults from abuse during their period of induction. We also saw that most staff had also completed refresher training. The care staff who we spoke with were clear about the action they would take if they observed an incident of abuse or received an allegation of abuse. They told us that they would ring the office to speak to a manager, and that they were certain the information would be dealt with following the agency’s policies and procedures. The agency has a policy on safeguarding vulnerable adults from abuse and the documentation we saw in the agency office evidenced that safeguarding alerts were submitted to the local authority as required.

Staff told us that they would use the agency’s whistle blowing policy if needed and they were confident that this information would be handled confidentially.

There were systems in place for any accidents and incidents to be reported to the office, recorded and analysed to check for any patterns or areas identified for improvement. The registered provider told us that if a significant incident occurred, a note would be recorded within the person’s care records and on the corresponding staff record (if appropriate). If the information needed to be known by all office staff, they would have to read the information and record within the database they had read it; the registered provider was able to check that all staff had recorded they had read this information. This meant that all staff involved in a person’s care had current information to follow.

The registered providers told us that, during health and safety training, care workers were told to check any equipment they used in a person’s home to make sure it had been serviced as required. They were told not to use the equipment if the date for servicing had expired, and to ring the agency office so that the registered manager could arrange for the relevant person to service the equipment.

We were told that there was someone ‘on call’ outside of normal office hours. In the past people had telephoned the agency office number and been put straight through to the staff member ‘on call’. There was now a pager system that was used when all lines at the agency office were busy, or 'out of hours'. This gave the caller the chance to speak to someone and to leave a message, which was put through to the pager for staff to deal with when they were available. The registered provider told us that the pager company also sent an email to the agency to 'back up' the messages so a record could be kept. People told us that the system was not as effective as it used to be. However, we did not receive any information that indicated people had not received appropriate care as a result of this change in the service.

We checked the recruitment records for three new members of staff. We saw that application forms had been

completed that recorded the person's employment history, the names of two employment referees and a declaration that they did not have a criminal conviction. Prior to the person commencing work for the agency, checks had been undertaken such as documents to confirm a person's identity, references and a Disclosure and Barring Service (DBS) check. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults.

Although there was no evidence that there were insufficient numbers of staff employed by the agency, we were concerned about the deployment of staff. One member of staff complained to us about excessive travel time between calls and how they had to hurry to try to meet colleagues for 'double up' calls. Other staff told us they could not stay with people for the full amount of time as they would be late for the next person. However, staff confirmed that they always completed all of the required tasks before they left the person's home.

None of the people who received a service from the agency raised any issues in respect of missed calls but people told us that staff were often 'in a hurry' and did not stay with them for the correct length of time. However, people told us that staff always completed the tasks that needed to be carried out and asked if the person needed anything else doing before they left. One person told us, "I do feel sorry for them (the care workers) because they are not given travelling time. I must say though, I do get my full time" and another person said, "Yes, usually on time, sometimes five minutes or so late but she does not take advantage. She finishes everything she has to do for me."

The registered provider demonstrated the electronic systems that were in place to assist in managing the service. The database recorded the name of every person who was in receipt of a service from the agency, including the number of calls they received each week and the duration of those calls. The system automatically assigned the same member of staff to a particular person each week; although this had to be changed on occasions for a variety of reasons. If a different care worker needed to be allocated, the system would identify a member of staff who had visited previously. In addition to this, when a person was discharged from hospital the system automatically allocated the same care worker that the person had before their admission. The system also allowed agency staff to plan routes and measure journeys taken by care workers so that they could be paid mileage. We saw the staff rotas that were produced by this system.

Prior to the inspection we had received information from the local authority and the registered provider about a number of medication errors that had occurred. The registered provider told us that these had occurred at the beginning of 2015 and two service users had been involved. When this had been identified, a regular group of care workers were allocated to these two people and all staff who had made an error had been required to undertake further training. No further errors had occurred.

The training record we saw indicated that all staff had completed training on the administration of medication, and the staff we spoke with confirmed this. The registered providers told us that medication records were reviewed by agency staff when they were returned to the office. This gave them the opportunity to monitor the records for errors or inconsistencies, and to identify staff who might require further training in recording of medication administration. The completed medication records we saw in people's care plans had been completed satisfactorily.

The people we spoke with told us that their medication was administered safety and no-one expressed any concerns. One person told us, "My carers give me my medication and I am happy to have that responsibility taken from me. I can be forgetful at times. I feel safer doing that; they know what I take and when I take it" and another person said, "My carers call and give me my medication. The staff know exactly what to do and I feel safe with them handling it. I have never ever had any concerns." We saw that care plans clearly recorded when people were able to administer their own medication, when family members assisted a person with their medication or when care workers from the agency assisted people with their medication needs.

When we visited the agency office there was no complete contingency plan in place, although there were various documents that advised staff what action to take in the event of an emergency. The day following the inspection, the registered provider sent us a copy of a full contingency plan. This meant that staff had easy access to one document that advised them what action to take in an emergency situation, such as a power failure or flood. The

Good

Is the service safe?

registered providers told us that the main risk of their business was the failure of the IT system. This information was 'backed up' every hour both on and off site, therefore the information would still be accessible in the event of an emergency and the agency would continue to be able to operate.

Good

Is the service effective?

Our findings

The registered providers told us that staff had previously undertaken induction training over a three day period, plus a number of shadowing shifts. The number of shadowing shifts depended on the person's previous experience and their confidence in carrying out their role unsupervised. However, the agency trainer had left the organisation so staff were currently receiving 'basic' induction training; this covered the topics of dignity, roles and responsibilities, confidentiality and the General Social Care Council's (GSCC) code of conduct. Staff continued to shadow experienced care workers as part of their induction training. Although staff had received appropriate induction training, the registered provider had plans in place to introduce a four day induction programme as soon as possible, and for an experienced care worker to mentor new staff; they felt this provided staff with a more robust induction to their caring role.

The agency had plans in place to ensure that all new staff completed the Care Certificate and they told us that some staff had already achieved this; the Care Certificate is an identified set of standards that health and social care workers are expected to adhere to in their daily working life.

The registered provider told us that they considered essential training to be moving and handling, medication, safeguarding adults from abuse and health and safety. All staff covered these topics briefly at the time of their induction to the service. The training records we saw indicated that all staff had completed refresher training on moving and handling and medication, and most staff had completed refresher training on safeguarding adults from abuse. Almost 50% of staff had completed refresher training on health and safety. The staff we spoke with were able to tell us about numerous training courses they had completed during the previous 12 months, including medication and moving and handling. This meant that staff had received the training they needed to carry out their roles effectively.

Training records evidenced that some staff had attended non-essential training such as end of life care, dementia awareness, infection control, catheter / stoma / convene care and Stroke. In addition to this, 28 of the 96 staff employed at the agency had achieved a National Vocational Qualification (NVQ) or equivalent at Level 2 or 3 in Care, and eleven members of staff were working towards a NVQ award.

Three staff at the agency office were trained to provide moving and handling training to care workers. We saw there was a bed and a hoist in the training room so that people could have practical training on transferring people. The agency also provided in-house training on safeguarding adults from abuse and medication.

Observed supervisions were carried out in a person's own home by the agency office staff. This allowed a care worker's practice to be monitored, and was also an opportunity for people who received a service to express their views.

The registered provider told us that staff had one to one supervision meetings with the registered manager every four months. They told us that the registered manager supervised all office staff and all care workers, and that they reserved time each Thursday to carry out this task. We saw that 'client' notes for those people who the care worker supported were printed out so that any concerns about the person, or any information received about the care worker, could be discussed at the supervision meeting. All of the staff we spoke with told us that they felt supported by the managers.

We asked people if staff seemed to have the right skills to effectively carry out their duties and the comments we received indicated that some people felt that mature care workers were more suited to the role. One person told us, "My carers always seem to be on training courses. They are good and they have life skills which younger ones have to come up against" and another said, "Young ones could do with some training on how to make a bed and in life skills. Everything takes time to learn but you have to want to learn and I sometimes wonder if some of the young ones just see it as a job." The registered provider told us that new staff had training on life skills as part of their induction and that this included lighting fires, making beds without duvets and denture care.

Staff had completed training on the Mental Capacity Act 2005 (MCA) in their induction training. This training informed staff to assume people had capacity and that they needed to provide people with information to help them make choices and decisions. Staff were told that

people should be allowed to make unwise or unsafe decisions if they had the capacity to do so, that they should act in a person's best interests and apply the least intrusive option.

Care plans recorded whether people had capacity to make decisions and to consent to care. Most people who received a service from the agency were assessed to have the capacity to make their own decisions. Those people who lacked capacity to make decisions lived with a relative or carer. One person told us, "I think my carer is excellent. I have no problems at all; she knows what she is doing. She showers me and helps me dress. I can manage some things on my own and she respects my decisions." A care worker told us that they always asked people for permission before they carried out a task, even if the task was the reason for their visit.

Some of the people who we spoke with told us that they had assistance with meal preparation, and they expressed satisfaction with the support they received. People told us they could choose whether to have their main meal at lunch time or in the evening. One person told us, "I am helped with my meals because I am not able to cook myself. I get help at breakfast time and whilst she is here she makes me a sandwich for my lunch. I have meals delivered from (private company). I manage quite well with the help I get.

We saw that people's nutritional needs were assessed and any information about their dietary requirements was included in their care plan. Some people had more specific meal requirements and we saw that these were clearly recorded in care plans so that staff had information about how to prepare the meals. A small number of people required assistance with percutaneous endoscopic gastrostomy (PEG) feeding and others required their drinks to be thickened due to the risk of choking. Any care workers who assisted with these tasks had undertaken specific training.

We saw that pen pictures in care plans included details of the person's health concerns, including any health issues that might affect the time that they required a visit from care workers. Any health concerns that required specific support were clearly recorded on pen pictures, such as "Insulin dependent diabetic." One person told us that their relative required very specific support from staff, including assistance with a supa-pubic catheter. The group of staff who supported this service user had received training from a nurse at the service users home to ensure they had the necessary skills to assist them.

Care workers told us that they would assist people to contact their GP if they thought they were unwell. They said they would then inform the office so other care workers could be made aware the person was unwell and that the GP had been informed. This would also be recorded in the notes made each day in the person's care plan that was held in their own home.

The registered providers told us that they had introduced a new messaging system to ensure staff could be kept up to date about any changes in their weekly programme or any changes in a person's care needs. Care workers would be sent a text to inform them about a cancelled call, although they would not be sent a text to restart a call; this information would be passed on 'in person' to ensure the care worker received it. All messages received were recorded on the database and there was a system in place to record when the messages had been passed on and who by. This provided an audit trail to evidence when messages had been received, who they were from and when they had been actioned.

Good

Is the service caring?

Our findings

We asked people if they felt staff cared about them. The majority of people said that staff really cared, but two people felt that some care workers seemed to do the work because it was a job and "Their heart wasn't in it." However, everyone stressed that staff had never been unkind to them. One person told us, "I get superb care; they are lovely people and help me a lot. I could not do without them" and another person said, "I have about ten (care workers) who come on a regular basis. I am sure they care about me. All of them are kind and chatty. I like that, without them my day would be dull." However, one person said, "Some do and some don't seem to care. It is usually the young ones who just treat it as a job, not much in the way of compassion; I suppose it is an age thing."

Staff told us they felt most care workers genuinely cared about the people they supported. They told us that they would raise any concerns with the agency office if they noticed any poor practice from other care workers.

Staff told us that they upheld a person's privacy and dignity. One person told us, "If I take people to the bathroom I close the door and the window. I put a towel over them and ask if they want me to leave the room" and another person said, "I give them time on their own if they want to use the toilet."

The registered provider told us in the PIR document that they had introduced the dignity champion scheme. This is when particular members of staff have a role in encouraging their colleagues to follow the agency's policies and procedures so that people are treated with dignity and respect. Every person we spoke with told us that care workers respected their privacy and dignity, and treated them with respect. One person told us, "Indeed they do treat me with respect and uphold my dignity. I am rather a private person at the best of times. When I am showering they are thoughtful in the way they keep me covered up as much as they can." Another person told us that staff showed them respect. They said, "(Care workers) never assumed they could just call me by my Christian name – they asked what they should call me. My privacy is respected – I keep talk around care and don't bring in any personal matters. It suits me best that way. What is private stays private." However, one person told us that too many staff referred to them as 'sweetheart' rather than using their name.

Other people also told us that staff respected confidentiality and did not share private information with them. The registered providers told us that each service user had a care plan in their own home and there was also a copy at the agency office. They told us that the agency copy might have additional information, for example, if a person had been diagnosed with early-onset dementia but they were not aware of this. This ensured that information shared with the agency remained confidential to the people who needed this information to provide optimum care, but was not shared with people who did not need to know.

Four surveys were returned to CQC from people who received a service from Elizabeth Homecare Limited; they all told us that the support they received from care workers enabled them to remain independent and to continue to live at home. One care worker told us, "We always promote independence and only help where it is needed." Another care worker told us about people who received an intermediate care service. They said they initially assisted people with tasks, but gradually moved towards watching them carry out the tasks to help them regain independence.

We saw that the agency website included links to the local authority, the Care Quality Commission and AgeUK. This enabled people to access advice about care services, including advocacy. The registered providers told us that they would also add information about available advocacy services to the agency service user's guide.

The registered providers told us in the PIR document that people could 'exclude' particular care workers. People told us that they had told the registered manager on occasions that a particular member of staff did not suit them, sometimes due to a personality clash or sometimes due to their age. This had always been respected by the agency office.

People told us that care workers recorded information in their care plan at each visit to ensure that all staff were aware of their current care needs. The registered providers told us that daily record sheets were returned to the office periodically so that they could be checked. This enabled agency staff to check that recording was respectful and accurate, and that any concerns identified by care workers had been passed to the agency office.

Good

Is the service responsive?

Our findings

The registered provider told us that the registered manager carried out an introductory visit to each person who requested a service from the agency. An assessment was carried out and staff were allocated to carry out the required tasks. We were told that, during the first two weeks, the person may not receive a service from a regular group of staff, but they would be given a list of all staff who would be attending them during this period. They would be asked to note any staff who they did not wish to receive a service from, and the agency staff would try not to allocate that care worker to them on a permanent basis. They would have another visit from agency staff within four weeks of the service commencing so that their ongoing needs could be discussed. After that, they would receive an annual review. When we were at the agency office we saw the list of reviews that were due in October 2015. The registered provider told us that agency staff also attended a three month review with the local authority if they had commissioned the service.

All of the people we spoke with told us that they had a care plan, and that it had been reviewed during the previous twelve months. People told us, "Yes, I do have a care plan. It was reviewed a few months ago and it is done every year by one of the staff from the office" and another person said, "Yes, I have a care plan. I had a review a couple of months ago. I get help four times a day. Staff help me to get up out of bed and make my breakfast. I have a shower three or four times a week – I decide. They do me my lunch and come back at tea-time and make me a sandwich. Last thing they do is get me into bed. I am very happy with the help I get."

Staff told us that pen pictures included enough information for them to understand about the person and how they wished to be supported. We saw that pen pictures in care plans recorded information about a person's physical well-being, psychological needs, communication needs, their likes and dislikes, medication needs, nutrition, any equipment needed, access arrangements, significant others and important health issues that might affect the time of the call they required. In addition to this, there was a sheet that recorded the actual times, days and duration of the visits the person required.

Some people told us that they also attended a review organised by Social Services where their care package was reassessed; staff from Elizabeth Homecare Limited would be invited to these reviews. This meant that everyone involved in the person's care was aware of their current care needs.

Some people had 'time sensitive' visits. Records in the agency office identified the specific time when people required a visit; this may have been due to their medication or their dietary needs. One person told us that these times were always adhered to although another person told us that they sometimes received a call up to 30 minutes before the required time. We discussed this with agency staff and they assured us the agreed time would be adhered to.

The registered provider told us that they used a pen picture so that, if staff were already familiar with the person's needs, they only had to read the updates that recorded any changes. When people had more complex packages of care they had a task sheet in place as part of their care plan. We saw that task sheets recorded very specific information for staff on how to provide this person with the care they required. The registered provider told us that, when care plans were updated, a copy would be sent to the relevant members of staff with their weekly rota. This ensured that staff were informed about each person's current care needs.

People told us that care workers always recorded details of the visit in their care plan. This meant that care workers had an up to date record of the care that had been provided and any changes in a person's care needs. One person said, "(Care worker) always looks in the book and she always writes comments in of what she has done for me."

We asked people who they would speak to if they had any concerns about the service they received. Some people told us they would ring the deputy manager and others told us they would contact Social Services. One person said, "I would contact the deputy manager. She is a wonderful person and I know she would help me to sort out any problems" and another told us,

"It would be no good trying to get the manager because I don't know her really. I would contact Social Services – they advised me to go into sheltered housing so they are responsible."

Good

Is the service responsive?

Information about the agency's complaints procedure was recorded on their website as well as in the service user guide and statement of purpose.

We asked to look at complaints and comments that the agency had received and noted that some complaints were recorded as 'notes' rather than complaints. Some of these notes were about missed calls. The registered provider acknowledged that these should have been recorded in the complaints log so that there was evidence about the action taken to reduce the risk of these shortfalls reoccurring. The registered providers told us that 'grumbles' were treated as complaints and that these were actioned in the same way as a formal complaint. The records we checked evidenced that people's complaints were listened to and responded to appropriately.

We asked the registered person if they worked with other agencies or organisations when providing a service for people. They told us that they worked with the NHS and the local authority to provide particular services (including pilots) for end of life care, a rapid response service and a service to people with long term conditions.

Requires improvement

Is the service well-led?

Our findings

The service had a manager who was registered with the Care Quality Commission. They had been in post for eight years and this provided a level of consistency for the agency.

We asked for a variety of records and documents during our inspection. We found these were well kept, easily accessible and stored securely; this was the case for both paper and electronic records. Services that provide health and social care to people are required to inform the Care Quality Commission (CQC) of important events that happen in the service. The registered manager of the service had informed the CQC of significant events in a timely way. This meant we were able to check that appropriate action had been taken.

We asked people if the agency seemed to be well managed and we received a number of concerning comments, including "No communication about sending in different carers because the carer is off on sick. I should be told" and "I don't think the management is sensitive to the client's needs." However, one person told us, "This is the very best agency I have had. I have left three others but this one is very good." All four respondents who returned a survey to CQC told us they would recommend the service to others. Another person told us that they sometimes requested support 'at the last minute' and that the agency office tried very hard to meet these requests.

We asked people if they received a service from a regular group of staff and responses were mixed. One person told us, "Basically I do get the same staff coming in to help me, but of course there are holidays and days off so you have to accept they do their best." However, another person said, "No, I get different people a lot. You can't make a relationship with anyone because of that."

We also received a mixed response when we asked people if they were informed when a different care worker would be attending them. Comments included, "No, anybody can turn up, it's not specified who. I have to explain what they have to do for me. I should be told", "I get a list of who is coming every week. Sometimes it has changed because someone has not been able to come. Well you have to accept that happens" and "No, not usually told. I don't bother who comes so long as someone does come."

A care worker told us that staff provided good care to people and that staff genuinely cared, but that travelling from person to person and trying to get there on time was "Impossible".

Staff who we spoke with expressed concerns about this lack of consistency. They felt that people needed a regular group of care workers so they could gain their trust and get to know them. Staff said that they regularly received complaints from people about "Too many new faces."

We recommend that the registered provider reconsiders the arrangements in place for ensuring people receive a consistent service.

There was no call monitoring system in place so agency staff relied on people ringing the agency office if their care worker had not arrived.

Care workers told us that office staff were not as organised as they used to be. One care worker said that office staff were not open about incidents that had occurred and complaints that had been received, although they did not share any specific examples. Other staff told us, "Office staff are really nice to speak to but disorganised – always last minute", "Not organised but pleasant" and "They were all over the place, but getting better." However, we did receive positive feedback about the skills of the deputy manager.

Care workers told us that agency staff listened to their concerns but did not always take action. One care worker gave us an example of when they had reported an error to the office. It was listened to, but the same error occurred again three days later. This meant that although staff were confident that their concerns were listened to, they were not confident they were always acted on.

We asked the registered provider how the area covered by the agency was divided into 'patches', and they told us that the service was managed as one 'patch'. A different care coordinator completed the staff rotas each week; they devised the rota one week and then managed any queries during the 'live' week, with help from another care coordinator. We discussed whether this constant change in rota management affected the efficiency of the service and the registered provider told us they believed the system was working well.

Requires improvement

Is the service well-led?

We recommend that the registered provider reconsiders the arrangements in place for ensuring people receive an effective service from agency office staff.

The registered provider carried out a variety of audits to monitor that the agency was providing an effective service. We were shown these on the agency database and saw that they included the monitoring of complaints, missed calls, accidents and incidents, staff training, staff supervision and communication systems. When any areas for improvement had been identified, the registered provider had recorded the action that was required and when this had been completed. In addition to this, medication records and daily records were returned to the office periodically and these were checked by office staff to ensure that recording was accurate and appropriate.

We asked people if they had ever been asked if they were satisfied with the service they received. Everyone we spoke with (apart from two people who had just started to use the agency) told us they had received a satisfaction questionnaire. One person told us, "Yes, I got a questionnaire some time ago. I said I was happy with the help I get. I have no problems" and another person said, "Yes, once a year I am asked about how I feel about the help I get. I would not stay with them if I was not happy – it is OK as far as I am concerned." We saw a copy of the questionnaire and noted that it included questions about the consistency of the care package, complaints and satisfaction with care workers and agency staff.

The registered provider told us that they sent out the same questionnaire in March each year to approximately 30 service users, and usually received around 20 responses. People were asked to score each question, and there was space available for people to make comments. The responses were analysed and the registered providers made comparisons to the previous years results. The analysis was shared with each care worker. The registered provider to us, as a result of one survey, a more robust system was introduced to ensure that people received a telephone call if their care worker was going to be late. However, care workers and people who used the service told us that office staff sometimes told care workers that people had been informed they were going to be late. When the care worker arrived at the person's home they discovered that they had not been informed.

The registered provider told us in the PIR that the agency had "Experienced leadership"; the same directors had been in place for over 20 years and the registered manager had worked for Elizabeth Homecare Limited for 15 years, and had been the registered manager for eight years. We asked the registered provider to describe the culture of the service. They told us, "This is the area I grew up in and quality / feedback is important to me. We want to do it right." They told us that this expectation was implicit in the agency's aims and objectives and included in their induction programme.

The information we saw in the agency office and through discussion with the registered provider showed that they kept up to date with developments in the care sector. They told us they checked relevant websites and were receiving information from the local authority, the National Institute for Health and Care Excellence (NICE), Skills for Care (a nationally recognised training resource), the Social Care Institute for Excellence (SCIE) and CQC. This included circulating information to all staff about the newly introduced Care Certificate.

No satisfaction surveys were distributed to staff. Some care workers told us that previously staff meetings had not been held on a regular basis but they had become more regular. Staff who had attended meetings told us they were able to express their views and were asked if anything about the service could improve. However, all the care workers who we spoke with told us they attended supervision meetings and that this gave them the opportunity to express their views about how the service was operated.

Some staff told us they enjoyed working for the agency but because of long working days and having to rush between calls, they were seeking alternative employment. People who received a service expressed concern that there was a high turnover of staff and they felt this was because too much was expected of care workers. One person told us that their relative's care worker was excellent but they were worried she was going to leave as she worked very long hours and had told them she could not continue. They told us, "She starts at 7.00 am and finishes at 11.00 pm."

The registered provider told us that the basic pay had been increased and this had helped the agency to recruit and retain staff. There were other financial incentives for staff; if

Requires improvement

Is the service well-led?

they worked before 8.00 am and after 10.00 pm they received an additional £1.00 per hour and if they achieved the health and social care diploma they were paid an additional 10p per hour.

Overall, we found that people were satisfied with the support they received from care workers but improvements were needed in the way the service was managed.