W&S Flint Services Ltd

Bluebird Care East Devon

Inspection report

Pendennis House
Gold Street
Ottery St Mary
EX11 1DG
Tel: 01404 814880
Website: www. bluebirdcare.co.uk

Date of inspection visit: 23, 28 September and 1 October 2015
Date of publication: 04/11/2015

Ratings

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

Overall summary

The inspection took place on 23, 28 September and 1 October 2015 and was announced. We previously inspected the service in April 2014 and did not identify any concerns or breaches of regulations.

Bluebird Care is domiciliary agency that provides personal care to 42 people receiving personal care living in their own homes in Ottery St Mary, Honiton, Sidmouth, Whimple and the surrounding areas of East Devon.

This location is required to have a registered manager as a condition of its registration. It currently does not have a registered manager. However a new manager was recruited three months ago and has now applied to register. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People's legal rights were not fully protected. Where people might lack capacity for day to day decision making, staff did not carry an assessment of mental

Summary of findings

capacity to establish whether they had the ability to consent to their care and treatment. Records were unclear about what day to decisions people could make for themselves and about what decisions people might need support with. Staff were not implementing the provider's consent and mental capacity policy.

People were consulted and involved in assessing their care needs and signed their care plans to confirm they agreed with them. Risk assessments were carried out for each person, which identified steps staff needed to take to promote their safety and welfare. Staff were aware of these risks and were taking the steps needed to reduce risks and keep the person safe.

Staff knew about the signs of abuse and where concerns about suspected abuse were identified, they reported them to the local authority safeguarding team. The service worked closely with health and social care professionals to implement measures to safeguard people.

People received their medicines on time and in a safe way.

The agency had robust recruitment procedures in place for recruiting new staff. Previously, there had been some difficulties with staffing at the agency which meant there had been some concerns about reliability. In response, the provider had reduced the number of care packages provided to ensure the safety and quality of the service and people reported recent improvements. Staff arrived on time and stayed for the agreed length of time. Four new staff had recently been recruited and were undergoing a period of induction.

Most people and relatives thought staff had the appropriate skills and training to carry out their role. However, some relatives and professionals identified additional training needs. Staff also identified additional training needs in managing medicines, dementia, and in end of life care. The provider had comprehensive training arrangements for staff. However, most staff we spoke with were in their first year of employment and so far had only completed their induction training. The manager was aware of their additional training needs and further staff training was planned.

People were supported to maintain their health. Where any deterioration was identified, they were referred to health professionals for advice which staff followed.

People known to the agency as at risk of malnutrition or dehydration were supported and encouraged to eat and drink regularly.

People had developed positive and caring relationships with staff. They confirmed that staff treated them as an individual, respected their privacy and treated them with dignity and respect.

People were consulted and involved in their care plans and signed them to confirm they agreed with their content.

People's care was individualised to their needs. Care records had detailed information about each person, their needs and preferences and what mattered to them. Care plans were reviewed and updated regularly although some lacked detail for people with complex needs, which the manager was aware of and was working to improve.

People knew how to raise any concerns or complaints and felt confident to do so. Where concerns were raised these were investigated and remedial action taken to make improvements. The provider was open and honest where mistakes were made, and offered apologies.

The culture of the service was open and care and office staff worked well together as a team. People and staff were very positive about the new manager and the improvements made at the branch since their arrival.

The provider had a range of quality monitoring systems within and external to the branch. These included a range of audits, questionnaires and checks on care and other records at the branch office and monitoring complaints and incidents. Where concerns or areas needing further improvement were identified, they were aware of them and were working to improve them.

The provider used a range of good practice initiatives to raise standards of care and promote good practice. These included recognising and rewarding staff and leadership and management development.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's individual risks were assessed and actions identified for staff to reduce them as much as possible.

People were protected because staff understood signs of abuse, and any concerns raised were investigated and reported to the local authority safeguarding team for further action.

People were supported by enough staff that arrived on time and stayed for the required time.

Accidents and incidents were reported and measures taken to reduce the risks of recurrence.

People received their medicines on time and in a safe way.

People were protected because staff recruitment procedures were robust.

Is the service effective?

Requires improvement

Some aspects of the service were not effective.

Staff offered people choices and supported them with their preferences

However, people's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005.

Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

Staff received regular training and ongoing support through supervision and appraisals. Although staff identified further training needs, there were plans to address these.

Is the service caring?

Good

The service was caring.

People and relatives said staff were caring and compassionate and treated them with dignity and respect.

People were supported by a staff they knew well and had developed relationships with.

Staff protected people's privacy and supported them sensitively with their personal care needs.

Is the service responsive?

Good

The service was responsive.

Summary of findings

People's needs were assessed before their care commenced and care plans were regularly reviewed and updated as their needs changed.

People received individualised care and support that met their needs.

People knew how to raise concerns and complaints, and were provided with information about how to do so. Any concerns raised were investigated and actions and improvements were made in response.

Is the service well-led?

Good

The service was well led.

People, relatives and staff all reported significant improvements at the agency in the last few months.

The culture was open and honest and focused on each person as an individual and the service was tailored to people's needs.

The service used a range of quality monitoring systems to monitor the quality of people's care.

The provider sought feedback from people, relatives and staff and made changes and improvements in response.

Bluebird Care East Devon

Detailed findings

Background to this inspection

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

This inspection took place on 23 and 28 September and 1 October 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; so we needed to arrange to visit and phone people to get their feedback.

The inspection team was an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for an older person who uses this type of care service.

Prior to the inspection we reviewed information about the service from the Provider Information Return (PIR), and other information we held about the service. This included correspondence with the provider about the absence of a registered manager and information received from the provider from statutory notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We spoke with 20 people using the service or their close relatives, and we looked at nine people's care records. We spoke with 12 staff, including the provider, manager, trainer, as well as with care and office staff. We looked at four staff records, and at incidents and complaints, training and at quality monitoring records such as audits and survey results. We sought feedback from health and social care professionals and commissioners of the service and received a response from three of them.

Good

Is the service safe?

Our findings

People and relatives said they felt safe with staff visiting them at home.

Staff received training in safeguarding adults and were familiar with the types of abuse that should be reported. All staff said they could report any concerns to the manager and were confident they would be dealt with. The provider had safeguarding and whistle blowing policies in place to instruct staff how to report concerns. Contact details for the local authority safeguarding team were prominently on display at the branch office. Minutes of a recent staff meeting showed a discussion between staff about the different types of abuse.

During the inspection, a safeguarding concern was identified in relation to a person whose deteriorating mental health was putting them and staff at risk. This was appropriately reported to the local authority safeguarding team and urgent assistance for the person was sought from their GP and mental health team. The manager liaised closely with the family and health and social care professionals to identify ways to protect the person.

People's initial assessment included individual risk assessments and identified ways to manage and reduce individual risks for people. For example, in relation to risks of malnutrition and dehydration, medicines and skin breakdown. Some people had agreed that staff could use a key safe to access their home, for their safety and protection.

Accidents and incidents were reported and reviewed by the manager who identified ways to reduce risks for each person as much as possible. Environmental risk assessments were completed which highlighted any risks for the person/staff in the home such as any slip, trip or fall risks. One relative described how a person living with dementia was at risk of burning themselves with the kettle. They agreed with the agency that the kettle would be locked in a cupboard when staff or relatives were not in the house. Staff were aware of the need to lock away the kettle, after each visit, although the risk assessment had not yet been updated to include this information.

People received rotas each week which showed their visit time and the name of staff which would carryout each visit. Where changes were made or staff were unavoidable delayed, people said the agency usually contacted to let them know. Some people and relatives reported that previously, there had been a lot of staff changes. This meant there were lots of visits by different staff, which was difficult and confusing for some people. However, most people said this had improved significantly recently and they now had a smaller number of staff who they had got to know well. Staff arrived on time and stayed for the agreed time. One relative said, "They take their time and are never in a hurry."

The manager confirmed that previously there had been some staffing difficulties which had led to …. In response, the provider agreed to reduce the number of care packages being provided so as to increase people's safety. The provider had changed their staff recruitment arrangements by advertising in local newspapers with some success. Four staff had recently started at the branch, a supervisor and three care staff who were undergoing induction. The provider was trying to recruit more staff for weekend visits.

A few people said they wanted to change their visit times to one more convenient for them. We followed this up with the manager who explained that currently people's visit times were prioritised according to their care needs. This meant priority was given to people needing time critical visits, for example for help with their medicines. However, they hoped to review this further once the new staff had completed their induction.

All appropriate recruitment checks were completed to ensure fit and proper staff were employed at the agency. All staff had police and disclosure and barring checks (DBS), and checks

of qualifications and identity, and references were obtained. The DBS helps employers make safer recruitment decisions and prevents unsuitable people from working with people who use care and support services.

People received their medicines on time and in a safe way. Staff that prompted people to take their own medicines or administered them were trained and assessed to make sure they had the required skills and knowledge. Although records of most medicines administered were well documented, there were some gaps in recording seem in some medicines administration record (MAR) charts. However, medicines administration was recorded in those people's daily records. The manager was aware of this as

Good

Is the service safe?

MAR charts were audited regularly and any discrepancies or gaps in documentation were followed up. Any medicines errors were reported and action taken to improve medicines management and therefore people's safety.

Staff contacted local pharmacies on people's behalf to chase up any missing medicines to ensure they received all their medicine supplies on time. Changes in people's medicines were updated quickly, for example when a person was prescribed antibiotics by their GP.

People confirmed staff washed their hands before and after providing care. Staff used personal protective equipment such as aprons and gloves when providing personal care, which reduced the risks of cross infection.

Requires improvement

Is the service effective?

Our findings

People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005 in relation to consent. The MCA provides the legal framework to assess people's capacity to make certain decisions, at a certain time. When people are assessed as not having the capacity to make a decision, a best interest decision is made involving people who know the person well and other professionals, where relevant.

Staff promoted choice and sought people's consent for all day to day support and decision making. However, where people appeared to lack capacity, stage one mental capacity assessments were not undertaken to assess people's capacity to consent for themselves. Care records were vague about some people's ability to make decisions and said things like, "Has some memory problems", or "has Alzheimer's". This meant there was a lack of clarity about whether or not the person had capacity to consent for their care.

The agency's consent and mental capacity policy reflected current legislation and guidance. It set out staff roles and responsibilities for obtaining consent. Staff responsible for obtaining consent had undertaken some initial training on consent and the MCA at induction. However, staff were not familiar with the agency's policy on consent. They were not using the provider's mental capacity assessment tool and best interest framework during the initial assessment, or when the person's mental capacity appeared to fluctuate or deteriorate. This meant where people lacked capacity, it was unclear from the care records who needed to be consulted and involved in any 'best interest' decisions made about the person.

For four people whose care we looked at, consent for care and treatment had been inappropriately obtained on behalf of the person from relatives/friends of the person. This was because their representatives had Lasting Power of Attorney (LPA) for the person's finances, not their personal welfare. This meant consent was obtained from representatives not legally authorised to do so, which was not in accordance with Mental Capacity Act 2005 and its code of practice.

This is a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

In practice, relatives and others were appropriately consulted and involved in discussions about people's care in their 'best interest', where appropriate. Care records included a section on how to support the person with decision making although, for people who lacked capacity, those records lacked sufficient detail about how each person could practically be supported to make as many decisions for themselves, as possible.

Most people and relatives thought staff had the appropriate skills and training to carry out their role. However, two relatives commented on the variable skills and experience of staff in managing more challenging behaviours of people living with dementia. For example, how some staff were better than others at prompting the person to take their tablets or to accept help with personal care. One health professional also identified staff skills related to end of life care as an area for improvement.

Most of the staff we met and spoke with were in their first year of employment at the agency and so far, had only completed their induction training. Although staff did medicines management training as part of their induction, three staff said they felt they needed more training in this area. The manager was aware of this need and planned to undertake a training session on medicines management at the next monthly staff meeting. Other staff also identified additional training needs in relation to working with people living with dementia and in providing end of life care. The manager confirmed this training was available and staff were booked to undertake it in the near future.

The provider had a comprehensive training programme to ensure staff had the right knowledge and skills and supported them to gain qualifications in care. This was available at different stages in their career. At the beginning of their employment staff undertook a two day induction training. A staff member described the range of training they completed when they first joined the agency. This included medicines management, safeguarding, health and safety, food hygiene and practical moving and handling training.

In the provider information return (PIR), the provider outlined how, as part of the induction training, staff were provided with information and given the opportunity of role play to learn how to deliver care to people with various conditions, including Parkinson's disease, following stroke and for people living with dementia. Staff at the Exeter branch had provided training and support to office based

Is the service effective?

staff at the East Devon branch when they first started working at the branch. For example, support for the new co-ordinator on developing rotas and to a staff member responsible for undertaking the initial assessment of people's needs and any risks. The manager was due to undertake a 'train the trainer' course in moving and handling so they could train other staff and improve the detail in people's moving and handling care plans.

The agency's training had recently been updated to incorporate the national skills for care, care certificate, which is good practice. Three newly appointed care staff were undertaking their care certificate training. When they first started, new staff worked with a more experienced member of staff to get to know people before they visited alone. This included the opportunity read people's care plans to find out about their care and support needs. All new staff had a probationary period, and regular 'spot checks' by supervisors to provide practical support and training, and assess their skills and competence to ensure good standards of practice. Once staff had completed their probationary period they could access further training relevant to the people they supported.

The provider had a range of development opportunities available for staff so they could could access a range of experience, training and qualifications specific to their role. Training covered subjects such as dementia, mental health and end of life care. The provider had employed a trained community nurse and to assist with staff training on particular medical conditions, for example, diabetes. They had recently added first aid to the staff training.

All care staff had regular support through supervision which included face to face meetings, by telephone and through 'spot checks' in people's homes. For example, one member of staff said how their recent 'spot check' had emphasised the need for them to check the person's care records at each visit to update them about any changes.

There was an annual appraisal system during which staff received feedback on their performance and identified any additional training and development needs. This showed the agency supported staff to update their knowledge and skills.

Staff had established good relationships and worked closely with local health professionals such as nurses, and GP's. Health and social care professionals confirmed staff contacted them appropriately and followed their advice. For example, during the inspection, a person's mental health had deteriorated and the supervisor undertook a home visit to review their care needs, and identify any new risks. They updated the person's care plan and contacted their GP and care manager to request an urgent review for the person.

The provider supported some people who were at increased risk of malnutrition or dehydration. Although the level of detail in care plans was variable, staff knew those people well and how to support their needs in relation to eating and drinking. For example, the relative of one person who was a diabetic said the person was a bit forgetful and often said they would eat later and then forget to do so. A member of staff explained how they encouraged this person to eat and drink something during their visit. They described how they sat and chatted to the person whilst they ate their meal. The records showed they explained to the person why it was important for their health to eat and drink regularly.

Other staff described how they offered a person their favourite drink and made sure each person had a drink within reach before they left. Detailed records were kept of what each had eaten/drunk during the visit so that the next staff who visited were aware when they needed to prompt the person to eat or drink more at the next visit. This meant people were supported to eat and drink enough to maintain their health.

Good

Is the service caring?

Our findings

People described positive caring relationships with the staff that supported them and said they treated them with dignity and respect. They said the best thing about the agency was the staff. One person said, "They are all nice and friendly, I have not found a grumpy one." Other people described staff as "Cheerful and helpful" and "Gentle". A relative said, "Staff are caring and compassionate and I like the way we can work together." Another relative said, "Staff are all very nice, genuine and caring."

Staff were very positive and enthusiastic about their role and the people they cared for. One staff member said, "I enjoy making someone's day, it's very rewarding." People said they were treated with dignity and respect by care staff who visited them. Staff described how they protected people's privacy when providing personal care by closing doors and curtains and making sure the person was covered with a towel.

Staff were respectful, they always knocked to let the person know they had arrived, even when they were letting themselves in. Relatives said they appreciated how staff were courteous to them and included them by having a chat with them each day when they visited. One relative told us how, separate to the person's care records, they had a communication notebook they used to communicate with staff, which was very helpful for them. This meant they were aware of any concerns, when the person had refused to take their tablets and when any replacement toiletries were needed.

People confirmed staff carried out their wishes and preferences. All care records included entries about how people were given the information and explanation they needed. One person's care plan for personal care said, "I need prompting at times, however, mostly I would like to carry it out myself." Another person's care record in relation to medicines said, "Do not tell me, just remind me gently in a conversation."

People were treated as individuals and received personalised care that met their needs. Each person's care records included a section, "What is important to me", which incorporated details about the person's life, their family, any religious preferences, hobbies and interests and things that were important to them. For example, how one person went to a coffee morning on a Tuesday and bingo on a Wednesday.

Staff helped each person to maintain their independence by supporting the person to do what they could for themselves and only assisting when needed. For example, one person told us how they needed help to get into and out of the bath, which staff helped them with otherwise they could manage to bath independently. A staff member told us how they helped another person, who lacked confidence to go out on their own, to access their local community by accompanying them for social and leisure activities. The provider encouraged people to socialise by organising some customer outings every so often which people, relatives and staff were invited to attend. For example, a trip to visit the donkey sanctuary in July 2015.

The manager made us aware of an occasion where they acted as an advocate on behalf of a person. This was because they had noticed, that one person's advanced decision about resuscitation had been changed after their discharge from hospital without consulting them. They contacted the person's GP to make them aware, so they could take the necessary steps to investigate. For another person, they contacted a care manager for advice as they were concerned about whether, what the relative wanted staff to do for the person, was in their 'best interest.'

People's care records also included a section about how to their communication needs. For example, how staff could best help a person with a visual impairment and several people with hearing loss.

Compliment letters from relatives showed positive feedback from relatives about end of life care staff had provided. For example, how staff were "Always cheerful and helpful" and provided the person with "Care and humour."

Good

Is the service responsive?

Our findings

Before the service commenced, people were consulted and involved in an initial assessment and discussion about their care needs. Support for people included personal care such as washing and dressing, helping with preparation of meals, prompting people to eat and drink, and take their medicines. After the initial assessment, a follow up call was made to the person to check that their care package was meeting their needs and to make any changes or adjustments needed.

People were consulted and involved in any assessments and reviews of their care needs and signed their care plan to confirm they agreed with their content. Relatives and friends of the person were also consulted, where appropriate. Staff knew people they were caring for well, their circumstances and family history, and their needs and preferences for care. This included details of how the person wished to be addressed and such things as whether they took sugar or not in hot drinks. Care records showed people were supported to express their views and were actively involved in decisions about their care.

Care records included instructions for staff about how people wished to be supported during each visit. These were reviewed and updated regularly by care supervisors as people's needs changed. For example, one staff member described how they noticed one person's legs had become red and sore when they were applying their daily creams and contacted the district nurse to visit the person. Following the nurse's visit, the supervisor visited the person and updated their care plan to instruct staff about the advice given by the district nurse. Care plans for some people with more complex needs needed more detail. For example, a person with diabetes and memory problems needed to eat regularly to stay well. Their relative said they often told staff they would eat a bit later and then forget to. This important detail was not in their care plan, although several staff we spoke with were aware of it. Another person sometimes refused personal care and medicines but their care plan lacked details about other strategies to try when this happened. The manager had identified this and was working with the supervisors to address it.

Staff identified changes in people's need for support and took steps to address this. For example, one person's health was deteriorating and they now needed night support. The manager rang the person's GP and asked them to request this from social services. When staff reported visits were taking longer than planned, they reviewed the person's care to check whether the time allocated needed to be reviewed and increased, where needed.

Daily records were detailed and included information about the person's emotional well-being as well as any physical care provided. Staff described how they met people's care and support needs, which demonstrated they understood the principles of individualised care and what mattered to people. For example, one person was very appreciative that staff supported them to look after their cat so their beloved pet could remain living with them.

People and staff records were securely stored at the agency's office in locked filing cabinets, although we identified one unsecured confidential document, which we drew to the attention of the provider and manager.

The provider had a written complaints policy and procedure. Written information about how to raise concerns or complaints was given to people when they commenced the service and was kept in the folder kept in their home. People said they wouldn't hesitate to contact the office and speak to the manager with any problems.

One relative said they contacted the manager when they identified a concern about the person's medicines. They said, "She got onto it straightaway." The complaints log showed previously, there were a number of concerns about reliability, lack of continuity and some missed visits. These complaints were investigated and followed up and improvements made. For example, in the provider information return, the provider outlined plans to introduce an electronic monitoring system to alert office staff to any missed visits.

Where mistakes were made, apologies were offered and people were made aware of positive actions taken to address concerns. For example, where a complaint was made about the timing of visits, these were changed where possible. In response, the person said, "This has made such a difference to the day." The provider was made aware of all complaints and reviewed actions taken to ensure they were addressed. This showed the provider took complaints seriously and used them to identify areas for further improvement.

Good

Is the service well-led?

Our findings

The service has not had a registered manager for eighteen months since the previous one left. We had previously corresponded with the provider and asked them to address this. A new manager was appointed three months ago who submitted an application to register since the inspection, which is now being processed.

The culture at the agency was open and honest. People and relatives said the provider and manager were approachable, two relatives said they felt able to talk openly and honestly to them about their relative's care. They said the provider and staff were upfront about any problems and what they were doing to address them. Staff said the manager had an "Open door policy."

The provider had a comprehensive staff handbook which set expectations for staff practice. The provider set out their vision and values for the service in their handbook and at staff induction training. This included excellence, honesty, being customer focused and their commitment to staff learning and development.

Some people and relatives told us about previous difficulties at the agency in relation to communication and reliability. However, they reported changes and improvements at the branch since the new manager started. One person said, "I'm very happy with the service I can't fault it." Another said, "They're perfect, I can't complain about them." People and relatives reported the agency was more reliable and described recent improvements. For example, contacting the branch office and getting a timely response and receiving regular rotas. Since the recruitment of a new supervisor two weeks ago, there was a full team of staff at the office.

During the inspection, we identified one missed visit related to a person who needed a time critical visit. This was reported to the agency by their relative who made sure the person was safe and gave them their medicines and something to eat. We followed this up with the manager and provider and found the incident was thoroughly investigated and was related to a communication error regarding the rota. The manager apologised to the person and relatives and outlined immediate additional steps they had taken to check the person was receiving all their daily visits.

At the time of our visit, the agency did not have a 'real time' monitoring system for checking that people receive their visits, and that staff stay for the required period. This means they were reliant on people, relatives or staff to let them know about any problems. We followed up progress with plans to introduce a call monitoring system, which would identify any missed visits very quickly and enable remedial steps to be taken. The provider confirmed staff had been trained to use the system and they were awaiting delivery of the equipment needed. They said they anticipated this system would be implemented in the next few weeks which will reduce risks and improve safety for people using the service. Meanwhile, the rota system clearly identified which people are most vulnerable so that where there are any problems such as staff sickness, priority can be given to ensure those people receive their visits on time.

The provider had effective systems for monitoring staff performance and praised and encouraged staff or their work. They used good practice initiatives to recognise and reward staff. These included a "Carer of the month" award to recognise and reward good practice, whereby people and relatives were invited to nominate a care worker for the award. The provider also encouraged staff retention through recognising and rewarding staff with bonuses for length of service.

Staff were positive about the recent improvements. One said, "Lots of things needed sorting, now things are definitely on the up." Another said, "The knowledge and support from office is improving", and "(Name) is putting things right, getting to grips." Other staff told us how office and care staff were now working much better together as a team.

The provider had a range of policies and procedures in place to support staff in their work. This included a whistleblowing policy whereby staff could raise concerns in confidence. Staff were encouraged to report any concerns and felt listened to and well supported. For example, one member of staff suggested that the branch office displayed and advertising banner outside their office to try and recruit new staff. They said, "I suggested it and here it is."

Where concerns about the attitudes, values and behaviour of individual staff were identified these were followed up with additional supervision, training and monitoring. Where problems with performance persisted, these were dealt with through the agency's formal capability and disciplinary procedures.

Good

Is the service well-led?

At the agency office, records of any accidents and incidents were reported and reviewed which identified trends and showed that actions were taken to reduce the risk of recurrence. Notifications had been received from the service.

The manager had introduced regular staff meetings, minutes of the last two meetings showed staff were consulted and involved in changes and improvements. Information about individuals were discussed at team meetings so staff could raise worries and concerns and share good practice about what worked well. To improve quality and continuity of care for people, staff had been divided into geographically based teams and some care staff were piloting a new rota system. So far, the feedback was positive and there were plans to extend this.

The manager felt well supported by the provider who they said was very “hands on “ and visited the branch regularly. They had also worked closely with the registered manager at the Exeter branch, to learn about the agency’s systems and what worked well. They identified there were some capacity issues at the branch when they first arrived. They said the provider had been supportive of the changes they had made to reduce workload so they could concentrate on recruiting more staff and improving support systems in the office.

The manager had undertaken a staged improvement and said they felt the organisational changes made meant the branch were ready now to start taking on new packages of care. They planned to concentrate on developing the staff team further. They identified more detailed care plans and further practical training for staff as key areas for further improvement which they were working on. To improve medicines management, the manager had just introduced new weekly, rather than monthly MAR charts which staff said were clearer to follow. They planned to discuss medicines management at the next staff meeting to further improve practice in this area.

The provider had a range of quality monitoring arrangements in place. These included regular audits of care records and medicines management and seeking regular feedback from people through ‘spot checks’. In September 2015, a survey of people’s views had been completed which was still being analysed. The manager said they responses showed people had reported improvements in communication with the office and more continuity of staff visiting. A recent staff survey also showed staff reported big improvements.

In the provider information return (PIR), the provider also outlined changes they had made to the telephone system. This was so that people ringing the branch could get through to the most appropriate staff member. For example, the co-ordinator who organised the rotas or a supervisor. Out of hours, the agency provided on-call support for people and care staff, and newer staff particularly appreciated this support.

The provider said, “ I want the service to be brilliant, not big.” They outlined how they had invested in office support to help achieve this. The provider had recently reviewed their quality monitoring arrangements. A member of staff was employed to audit people’s care across all three branches of the agency. Their focus was to ensure reviews of care resulted in actions being followed through to improve people’s experiences of care. The provider used a number of performance indicators to monitor and compare performance, such as recruitment and retention, staff sickness and continuity of care. They also organised occasional outings for staff, one staff member described how they had enjoyed a staff outing in the summer and meeting staff who worked at a neighbouring branch.

In the PIR, the provider outlined how they had accessed the governments "Growth Accelerator" programme. This was to access funding to support the leadership and management development of managers. supervisors and other staff. The manager confirmed they had attended the first two days of their management development training at Head Office, which they had found very helpful. Other office staff were also due to undertake further development and training as part of this scheme.

The provider outlined other creative ways they used to promote high standards and drive improvement. For example, the provider and another senior member of staff had undertaken training to become “Dementia friends” champions and had done five dementia awareness training sessions within their local area. The provider and staff had also undertaken fundraising for the Alzheimer’s Society by sponsoring and taking part in a local community event to raise awareness of services for the elderly. The agency had a community grant scheme to support a voluntary organisation that supported people in their local

Good

Is the service well-led?

community. For example, in 2015, the branch awarded the community grant to the East Devon Parkinson's support group who ran weekly classes in the area for Parkinson's sufferers.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent How the regulation was not being met: People's legal rights were not fully protected because staff did not have a full understanding of the requirements of the Mental Capacity Act (MCA) 2005. This meant it was unclear whether or not people had the ability to consent for their care. This is a breach of regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

This section is primarily information for the provider

Enforcement actions

The table below shows where legal requirements were not being met and we have taken enforcement action.