Servicescale Limited

inTouch Home Care

Inspection report

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Date of inspection visit:
05 September 2017
12 September 2017

Date of publication:
05 October 2017

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?	Good

Summary of findings

Overall summary

inTouch Home Care is a homecare agency based in Barnet that provides services to people of any age. At the time of this announced inspection, they were providing personal care and support to 48 people living in their own homes.

The service did not have a registered manager at the time of this inspection. 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. The registered manager of the provider's other homecare agency based in Coventry was managing the agency on an interim basis in conjunction with the operations director.

At our previous inspection of this service, in July 2016, breaches of legal requirements were found. These were in respect of staff recruitment processes, staffing numbers, complaints handling, and the need for consent to care. At this inspection, we found all these matters had been addressed.

There were enough suitably recruited and skilled staff to meet people's overall needs. The service had many ways of ensuring staff had the knowledge and skills for their care roles, including regular checks of staff knowledge and practices.

People generally had the same small team of care staff visiting them. New staff were often introduced to people through known and experienced staff members. This all helped positive and trusting relationships to develop, and for people's needs and preferences to be well attended to.

People were treated well. Their privacy and dignity was respected and promoted, and their independence was enabled where possible. Consent to care was appropriately sought.

Good attention was paid to people's health, nutrition, medicines, and welfare, both at care visits and in feeding back concerns to the office so that further action could be taken. Staff felt supported and valued, which in turn helped them to provide the quality care service that people and their representatives told us about.

The service identified and addressed care delivery risks. This included protecting people from abuse, reviewing accidents and incidents, and considering complaints.

Our overall findings demonstrated the service provided high-quality care that was open to learning and improving. There were robust systems of auditing quality and compliance with regulations. The views of people and their representatives, and care staff, were incorporated into audits. The service operated a positive, open and empowering culture.

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. There were enough suitably recruited and skilled staff to meet people's overall needs. There were systems to keep risks to people's safety and welfare under review.

The provider took steps to ensure people were protected from abuse and that any concerns were fully investigated.

The service had systems to ensure people received safe support with their medicines.

Is the service effective?

Good

The service was effective. There were many systems for ensuring staff had the knowledge and skills needed to meet people's needs.

Good attention was paid to people's health, nutrition and welfare, both at care visits and where needed, in feeding back concerns to the office so that further action could be taken.

The provider had embedded systems to ensure people or appropriate representatives consented to care.

Is the service caring?

Good

The service was caring. People's privacy and dignity was respected and promoted, and their independence was enabled where possible. The service took steps to ensure its staff were caring.

People generally had the same small team of care staff visiting. New staff were often introduced to people through known and experienced staff members. This all helped positive and trusting relationships to develop.

Is the service responsive?

Good

The service was responsive. People's needs and preferences were attended to by care staff who knew people well as individuals.

The service had robust systems for seeking and acting on people's views, concerns and complaints.

Is the service well-led?

Good

The service was well-led. Although there was no registered manager, management arrangements at the service were ensuring the delivery of high-quality care. This included robust processes of auditing quality and risk. The service operated a positive and empowering culture, and valued input from people and their representatives.

inTouch Home Care

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.

This was an announced inspection that took place on 5 and 12 September 2017. We gave the provider 48 hours' notice of the inspection. This was because of its smaller size and as members of the management team can be out of the office we needed to be sure they would be available.

The provider completed a Provider Information Return (PIR) in advance of the inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

Before the inspection, we checked notifications made to us by the provider, safeguarding alerts raised about people using the service, and information we held on our database about the service and provider.

The inspection was carried out by two adult social care inspectors and an Expert by Experience, which is a person who has personal experience of using or caring for someone who uses this type of care service. Their involvement was limited to phoning people using the service and their relatives to ask them their views of the service.

There were 48 people using the service for personal care support on the first day of our inspection. During the inspection, we received feedback about the service from six people using it, six people's relatives, and two community health and social care professionals. We also spoke with nine care staff, three senior and office staff members, the interim manager and the operations director.

During our visits to the office we looked at five care plans and risk assessments for people using the service plus other records about people's care including visit schedules, medicines records and care delivery records. We looked at the personnel files of five staff members, complaint records, incident records and visit plans. We were also provided with, on request, further specific information about the management of the

service in-between our visits. This included specific policies and audit tools.

Good

Is the service safe?

Our findings

At our last inspection, we found instances where new staff were providing care to people before completing mandatory training and before reference checks of their previous employments were finalised. There were also not consistently enough staff with the right skills to meet the needs of everyone using the service. This meant the provider was in breach of regulations 18 and 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found these matters had been addressed. Records and feedback indicated no instances of staff providing care in people's homes before completion of induction training or being signed-off as fit to work. All staff received dementia training as part of their induction, meaning people living with dementia were attended to by suitably trained staff which helped keep them safe. Where staff worked with children, additional child protection training was provided.

Robust recruitment checks of new staff were taking place. Staff files and feedback from staff showed checks of identification, right to work, any qualifications, and employment histories and gaps. Criminal Record (DBS) and three written reference checks also took place before staff started visiting people in their homes. Reference checks included verbal confirmation phone calls to confirm the referee and gain further information. Reference checks included those from recent care employers but occasionally not from care employers from five or six years ago, which the service began addressing when brought to their attention. They also updated their recruitment policy and reference check forms to ensure no reoccurrence.

Recruitment records and staff feedback also showed new staff were checked for basic maths and English skills, along with sufficient knowledge and appropriate attitudes about care through employment interviews. There were subsequent checks of knowledge and attitude during induction training, after shadowing experienced staff, and through competency checks when working alone. In this way, the provider was taking many steps to ensure staff were suitable for their roles and kept people safe.

At this visit, we found there were enough suitable staff to meet people's needs and keep them safe. People and their relatives fed back no significant concerns about timekeeping and no-one reported missed visits. One person said, "They are sometimes a bit late but never so much that I'm worried. As long as they come, I don't really mind."

When we checked the provider's computer system during the first day of inspecting, we found no unallocated visits for the next seven days. Most visits for the next month had been allocated. This showed the service's system of making sure each planned visit to everyone in the near future was working well, and indicated there were enough staff to undertake all planned visits. Records also showed there was consideration of whether or not there were enough capable staff to accept new care packages.

Everyone told us the service was safe and staff knew what they were doing. One person said, "It's essential that I have someone to help me in the shower because I have had some blackouts in the past but I feel very safe with my carer. She makes sure I don't slip or anything." Another person told us, "They help me to

transfer from the chair to the wheelchair to go out and they really do keep me steady. I have no doubt they are well trained." A relative said, "My relative is very safe with the carer. I have absolutely no worries at all about safety." Another relative told us, "I can't think of any improvements they could make. They are very methodical."

One person told us when they first started using the agency, "They did a risk assessment of the house and made a few recommendations for me to think about." A staff member gave an example of feedback they received on bed-rail use which helped them improve the safety of their care. We saw up-to-date risk assessments in respect of everyone using the service. Along with assessing environmental and care risk, there were specific forms used if needed. For example, for moving and handling, finances, and where bed-rails were used. Action plans were in place arising from these processes where needed, and records in the service showed these were followed-up on. For example, phoning the person's family where environmental adjustments were needed. Office records showed that everyone's risk assessments were reviewed annually or sooner if needed.

A few people were identified to be at risk of choking when supported with food or drink, for which the service took some actions to address risks. One child's care plan clearly informed staff of this risk and only their parents were to provide assistance with food or drink. Records showed close liaison between the service and a community healthcare professional where another person had become identified as at risk of choking. Senior staff told us of practical measures they had taken to ensure staff supported the person safely, such as contacting all staff involved in the person's care with updates. We saw their care plan had an extra page on the additional support needed. However, their risk assessment had not been updated to reflect the increased risks, staff had not received training on understanding choking risks (dysphagia training), and the provider had no specific policy on dysphagia support. We were sent a robust plan of action to address these concerns shortly after the inspection.

Some staff told us of completing body charts, if people they visited had bruises or cuts. They added they would contact the office if they had safety concerns. Office records confirmed such instances. For example, where one person had a fall that was not reported by the staff with them, records showed another staff member alerted the office. This helped ensure the person was safe and that the former staff member was informed of the action they should have taken. Subsequent records for that staff member showed they were now reporting any safety concerns arising at their visits.

People supported to take medicines said their tablets were handled and recorded safely. One person said, "They sort out my tablets for me. They never touch the tablets with their hands but they still wash their hands before they give them to me. They make sure I've managed to take them with a drink of water and then write everything down."

Staff told us of medicines training when new, such as removing medicines from dosette boxes without touching tablets and repeatedly completing medicines records until they were recording them correctly. Practice was also assessed during shadowing visits, for which we saw corresponding records on staff files.

A staff member told us of making a record of a person dropping a tablet and not taking it. A relative then arranged a replacement tablet. We found an appropriate record of such a scenario in one person's recent medicines records. Staff told us they would record and also inform the office if someone did not take their medicines, and the office would contact relevant people such as the GP or relatives.

A staff member told us medicine records were collected regularly from people's homes and any issues were followed up with staff concerned. We checked some of these audit records, which were used to monitor and

improve on the safety of medicines support. The medicines records and the audits were helping to ensure people received their medicines as prescribed.

An office staff member told us any medicine changes would be reflected on an updated medicine chart. All staff supporting the person would be informed by phone or alerted by text, with acknowledgement of receipt of the update required. This helped ensure people still safely received their medicines if a change in the prescription occurred.

Records and management team feedback showed us the provider had systems for identifying potential abuse, and took action where abuse was suspected. Abuse concerns were promptly reported to the relevant local authority whose questions were duly answered. The service's summaries of investigations included clear action plans to minimise the risk of the concern reoccurring.

The management team gave examples of what the safeguarding training included, such as staff being told to write the exact time of arriving and leaving people's homes within the person's record of care. Staff could tell us common abuse scenarios. One explained staff should not be handling money unless a shopping call was part of the person's care plan. This helped protect both the person and the staff involved. Staff told us they would report any suspicions of abuse to the office staff immediately. One staff member gave us an example of having done so, which resulted in office staff taking action. Staff were also aware, from training, of what to do if no action took place and which other organisations they could contact.

Good

Is the service effective?

Our findings

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. At our last inspection, where people lacked capacity to consent to care services, the service had not documented a capacity assessment and, where necessary, follow a best interests process. This meant the provider was in breach of regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found these matters had been addressed and the provider was working within the principles of the MCA. We saw appropriate capacity assessments in people's files in respect of aspects of their care. Where assessed as lacking capacity for a decision, there were brief details of best interest decisions including the involvement of people's family members. Care files had information and copies of formal documents on any relevant legal considerations such as Lasting Power of Attorney (LPOA) or Do Not Attempt Cardiopulmonary Resuscitation (DNACPR). Where the LPOA related to welfare, the involved attorneys had signed consent on behalf of the person for service documents such as care plans. The provider's computer systems included clear information on where the DNACPR form was in the person's home, to help with accessing it when needed.

Staff had some knowledge of the MCA to inform their work with people. Some told us this was mainly about people's ability to make their own choices or decisions, with relevant information being in care plans such as capacity assessments and guidance on any circumstances where restrictions were formally in place. Staff were mindful they should respect people's wishes and could not force people to do things. They said they try to explain to people the importance of the care being offered, or give people time and space then try again later. All said they would report any refusals to the management team for monitoring purposes and liaise with relatives and community professionals as appropriate. For example, one staff member told us they had been unable to persuade someone to stand to go to bed, when it was already quite late at night. They rang the on-call staff who contacted a nearby relative who visited and persuaded the person to stand. Records in the office confirmed refusals were reported and appropriate action taken to support people's welfare.

Overall people and their relatives told us this service was excellent. People were well cared for and staff were well trained and dedicated. One person said, "The carer really goes the extra mile all the time." Another person told us, "I don't always get the same carers but I don't mind because everybody I've had has been really good. I tell them what I need help with and they get on with it." A relative said, 'I think they are all well trained and know what they are doing." Another relative told us, "I can't fault the regular carer. She is

marvellous. My relative struggles to tell me things but I know he's happy because he always smiles about her."

Staff were full of praise for the training and support provided. One staff member summarised the strengths of the service: "Training is absolutely 'A1', the support at the end of the phone, supervision." Another staff member spoke of the training being "thorough and interesting."

Some staff told us of being supported to take national training courses such as NVQs. Others told us of undertaking training in regard to challenging behaviour, autism, epilepsy, or palliative care, as people they provided care to had needs in those respects. There were records of these courses in the staff files we checked.

Records and staff feedback showed new staff attended a four-day induction program that covered many topics in line with initial expectations of the national Care Certificate designed for care staff. The training was provided in a classroom setting, and included practical skills such as hoisting people and emergency first aid. Written tests were undertaken for each component, and were marked to ensure each staff member had sufficient knowledge to progress. Staff also told us of some online learning, and that home-based training occurred for specific equipment in line with risk assessment processes.

New staff then completed between five and ten hours of documented work shadowing experienced staff members in people's homes depending on experience. Extensive records of their capability in these settings were made before a member of the management team formally approved of them working alone if the staff member was also ready for this. We saw records of new staff having further shadowing with senior staff where someone had more complex needs or where requested by the person or their family.

The management team told us new staff were more closely supported in their first six weeks of work, including unannounced visits to check on the work (spot-checks), competency checks, and by ringing them to see if they needed any help or support. Records on staff files and the provider's computer systems confirmed these occurred promptly. A newly-employed staff member told us they had already undergone spot-checks and this had led to their hours being increased, because of positive feedback also received from the person they were providing care to. Another newer staff member told us senior staff attended their first shift and later phoned them to check how it went and if any particular support was needed.

The management team told us spot-checks occurred if there were concerns with staff performance such as after a medicines error. This would follow an immediate supervision meeting with the involved staff member to discuss the improvement needed.

Staff told us of receiving regular supervision sessions in which they discussed their work, both in terms of what they thought and through feedback from the supervisor. The meetings included discussing care-related scenarios, and being questioned on topics to ensure they had sufficient knowledge. Most staff also spoke of annual appraisal meetings to review their progress across the last year and plan for the next one. Computer systems demonstrated all staff received annual appraisals and regular office-based supervision sessions.

People and their relatives had no concerns about nutritional support. One person told us, "I order in my meals and always have a stock of nice things in the freezer. We always have a chat about what I fancy today and then the care worker gets it ready for me. She always sets it out nicely as well so that it looks appetising. She does me porridge for my breakfast with a bit of honey in it. It's lovely."

In terms of nutritional support, staff gave many examples of safe food handling practices along with encouraging people to eat and drink enough, ensuring people had food and drinks in easy reach, looking for signs of dehydration, and filling in food or fluid charts where part of the care plan. One staff member spoke of encouraging more drinks in hot weather and giving watery fruits or food if the person declined to drink. Another said they reported concerns to the office that a person was not drinking enough. The person's care plan was consequently reviewed to monitor their well-being in relation to this.

People's care plans included food and drink support needs where appropriate. Their care records included what food support they received, often stating exactly what they ate. Dietary restrictions and cultural or religious needs around food were also evident in care plans.

Records relating to each person on the provider's computer systems showed ongoing summaries of action taken about health related matters such as information from care staff and liaison with people, their family members and community professionals in support of healthcare concerns. As one staff member put it, "Our concerns are chased up." One person's file included a letter from a care worker raising concerns about one person's health. The provider's computer records for the person showed the concerns were subsequently discussed with community healthcare professionals. In another case, concerns raised about someone's welfare in respect of not being supported to take prescribed medicines was passed onto social workers. Staff supervision records also included discussions on some people's overall welfare, and weekly office staff meetings considered those people whose welfare provided most concerns, for example, because radiators were not working in someone's home.

Good

Is the service caring?

Our findings

People and their relatives said care workers were kind, compassionate and respectful. One person told us, "My regular staff is like a little mother to me." Another person said, "I have a bit of a joke with the carer when she does my tablets because she always checks my name. It makes me laugh when she asks if I'm still me."

Staff spoke about respecting people, how they lived, and remembering they were in the person's home. One said, "You treat clients as you would like yourself to be treated." Examples given of respecting people's dignity included keeping people covered during personal care, closing doors and curtains, maintaining boundaries such as by not asking personal questions, and using the person's preferred name which was evident within their care plan.

Senior staff checked on the caring approach of staff regularly. This included at recruitment interview, during shadow shifts with senior staff, during spot-checks visits and in supervisions. This helped ensure people were treated with respect.

Everyone told us they generally had regular care staff visiting them, which helped as those staff knew them well. For example, a relative said, "There's been a different carer when one of the regulars has been ill or on holiday but normally it's the same faces every time which is important." Most staff told us they usually supported the same people at the same times each week. One staff member told us the agency tried to keep the same few staff supporting each person, so a relationship of trust could be built up with the person. The agency's computer systems enabled familiar staff to be routinely allocated to people. It also prevented staff being reallocated to specific people if there was reason to prevent them visiting, such as due to a request from the person.

Records showed us many occasions of care staff contacting the office or the on-call team due to concerns with someone's care and welfare. There were often records of actions taken to address matters, such as through senior staff visits or phone calls to family members. For example, staff were concerned that one person was very sleepy and not themselves, but with no obvious health symptoms. Arrangements were made for a family member to stay overnight with the person. The person was more active a few days later. Records also showed when someone was visited who needed hospital treatment, arrangements were made for the care worker to stay with them until the ambulance had gone.

People told us the service got the balance right between helping them and enabling them to do things themselves. One person said, 'I think the carers are marvellous. They never do anything without asking me if it's alright even though they do the same things most days. I try to be as independent as I can and they encourage that. They don't make me feel helpless." Another person told us, "I try to do as much as I can for myself, to try and be a bit independent, but it's good to know they're there if I need them." People's care records showed they were supported to undertake tasks independently where possible. Care plans encouraged this.

People and their relatives said care workers were understanding around confidentiality. Staff files included

signed confidentiality agreements. Both the staff handbook and the user guide in people's homes clarified expectations around confidentiality, including what staff were required to report due to safety risks.

People told us they or their relatives were able to make their own decisions and that their preferences were taken into consideration. One person said, "When we first started, they came and went through everything I needed. They made it clear that if anything changes (in terms of the support needed) they will come and talk to me about it. It's very reassuring to be honest." A relative told us, "They came and talked to us about the care plan. They've made it very clear that if we find we need more support they can come and review things with us." One person's care preferences included single-gender care. The provider's computer systems showed this preference had always been followed.

The service had organised end-of-life training for some care staff based on occasional need amongst people using the service. The agency kept the needs of people receiving end-of-life care under close monitoring. Records showed plans were set up to meet religious preferences of one such person's family.

Good

Is the service responsive?

Our findings

At our last inspection, we found the service's complaints system was not consistently effective at ensuring concerns and complaints were listened to, documented and learnt from. This meant the provider was in breach of regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At this inspection, we found these matters had been addressed. People and their relatives said there was information about the service's complaints procedure in the agency's file in their house, but most people told us they had not had to use it. For example, one person told us, "If I was worried about anything I would have no problem in ringing the office. I think the communication from them is pretty good. I must say though that I've got no complaints at all." Another person said, "I have no complaints at all. This is by far the best agency around. I don't know what I'd do without them."

Care staff knew to report people's concerns and complaints to the management team, and felt people were listened to. Senior staff told us of meeting with people regularly, to review care or undertake routine checks on staff. At these times they could check on people's views of the service and address any concerns they had, thereby helping to avoid formal complaints being needed.

The service kept records on how any complaints were responded to and resolved, and what learning needed to be embedded to ensure matters did not reoccur. People raising complaints were sent letters acknowledging the complaints, and in due course, letters explaining what investigations occurred and the outcomes. These included options on what to do if dissatisfied with the response. There were sometimes records of follow-up contact, to make sure complaints remained resolved.

The management team kept an oversight of all complaints and concerns raised, to ensure they were addressed, and to analyse for trends. This helped to demonstrate that dissatisfactions expressed by people using the service and their representatives, not just those formally identified as complaints, were being learnt from.

People gave us examples of how the service met their needs and preferences. One person said, "My carer deserves to be commended. She is outstanding. I rely on her for so many things. When she helps me to shower she knows just how to hold my head to wash my hair and keep the shampoo out of my eyes. She's just brilliant." Another person told us, "I sleep in a recliner chair and the carer just knows when I'm not comfortable without me having to say anything and then she helps me to move my position. It's the little things like that which makes all the difference." A relative told us, "They are just amazing. They always have a chat with (my relative) and explain what they need to do. My relative can be really fussy and has set ways of wanting things done but they know that and do things that way if they can."

Staff told us everyone had a care file in their home, where they could look at care plans. One staff member told us the folders contained a 'My Life Story' document about the person they had been able to read during their shadowing visits. Records and feedback also showed us staff were sometimes introduced to people by senior staff, to help ensure the new care worker understood the person's particular needs and preferences.

Our checks of people's care plans showed them to identify people's specific needs and preferences, and guide staff on how to provide appropriate support. In some people's files, assessments of communication identified people relying on such things as reading glasses and hearing aids. However, these were not consistently transferred to people's care plans so that staff could easily recognise if the person needed help with any form of communication. We also identified that key safety risks identified in risk assessments were not always clearly highlighted within care plans. Whilst records showed some of that information was also conveyed to staff in other ways, and the feedback we received did not highlight concerns, the management team agreed to adjust care plans to ensure key information as described above was more prominent.

Care staff told us senior staff promptly updated care plans in response to calls from staff about changes in people's conditions or if staff felt planned care was not working well. Office records showed that most people's care needs were reviewed annually or sooner if needed. A quality assurance visit took place within six weeks of the care package starting, and then at least six-monthly, to check on satisfaction with services. Additionally, phone calls were regularly made, to check on people's satisfaction with the service.

The provider last undertook a survey of people's views on service quality in January 2017. Many people using the service and their representatives replied. An analysis document showed results were positive in the main, for example, for timekeeping and care quality. The management team told us there were no service-wide changes made as a result, but the process enabled improvements for individuals where needed.

The service recently set up its first user forum, to help get feedback on service standards and create more of a community feel to the service. A few staff told us this was organised in a park, where relatives of children using the service could go to give their views whilst the children played. The management team told us of a few people attending. They intended to hold these forums regularly and hoped to build on them.

Good

Is the service well-led?

Our findings

The service did not have a registered manager at the time of the inspection. The last registered manager left the role a year ago. The provider had appointed two managers since then. The operations director informed us the most recent manager left the role shortly before the inspection. The interim plan for managing the service was for the role to be shared between the operations director and the registered manager of the provider's other care service in Coventry. The plan included an application to add this service to that manager's CQC registration. However, there was ongoing recruitment for the permanent role, including interviews of candidates in-between our visits.

Shortly before the inspection, the provider informed us of an acquisition of their services by a specialist care industry recruiter and training provider, N-Trust Care Services. At the time of the inspection, a strategic review of the service was ongoing. The operations director explained there were no significant changes to the service, just additional resources available such as for staff recruitment processes. Documents we saw indicated the provider was continuing to operate the service. Staff told us they and people using the service had been kept informed of the changes which had gone smoothly so far.

The provider undertook regular audits of care quality, risk management, and compliance with the regulations, to identify shortfalls and areas for improvement. Records showed extensive audits of files of both staff and people using the service in the early months of 2017. This was to check appropriate documentation was in place such as for staff recruitment and reviews of people's care packages. Whilst generally positive, these clearly identified any shortfalls so that action could be taken to address matters. The management team told us of changing the format of people's care plans and risk assessments as a result of the audits, to connect together better. These were now being used for people newly using the service and where others had recent care reviews.

There were regular audits of people's care and medicines records. The audits identified issues such as when staff arrived 20 minutes apart when they were scheduled to visit together. A staff member told us they received constructive feedback from the audit process.

The provider received weekly reports on a range of service data by which to help monitor service standards. Records showed this included data on staff recruitment and supervision, and checks on service quality in people's homes.

The management team took note of feedback we provided throughout our visits. They presented us with action plans at the start of our second visit, and shortly after the visits, to show that any suggestions for improvements were being attended to. They also showed us what had taken place, such as revised or new forms, that would help improve the service. This all demonstrated a commitment to improving the service and delivering high quality care.

We found the service to promote a positive and open culture. Staff told us of good support from the office. One staff member said the service's biggest strength was "communication, at any time of day." Another care

worker told us good communication with the office "improves the service user's life." A third told us, "Anything I have to say, they listen to it," citing as example a request for training on palliative care that was subsequently provided. All staff thought the service was well-managed, and that they would recommend it if friends or family needed care. Some told us of having already done so.

Staff were positive about the out-of-office-hours on-call system and support, which they had used to seek advice or report changes in anyone's condition. The on-call person was always someone from the management team. They had a work laptop with easy access to information they might need.

Most staff told us of occasional staff meetings. These were held at different times of the day to enable easier attendance. Staff told us these covered such things as training opportunities and policy updates, which they found useful.

People's records were securely stored at the service's office, in locked cabinets and password protected on computer systems. The provider was registered with the Information Commissioner in respect of handling people's information on electronic systems.

We were given open access to all service data on the provider's computer systems, which demonstrated transparency. It also showed us extensive records were kept, such as the many phone calls with people using the service and their relatives.