Routes Healthcare (North) Limited

Routes Healthcare Yorkshire

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Routes Healthcare (Yorkshire) is a domiciliary care agency which provides personal care to people living in their own homes. The service currently provides care in the Halifax area of West Yorkshire with its office base located in Bradford. Referrals to the service are usually from the local clinical commissioning group (CCG). At the time of the inspection 19 people were using the service.
A registered manager was in place. 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 and their relatives provided mixed feedback about the quality of the service. Most people said they were happy with the care and support package provided by the service. However
three relatives raised concerns over the timeliness of calls stating that due to erratic call times people were not receiving appropriate care and support. A further two relatives raised the timeliness of calls as a more minor issue. We looked at six people's care records and saw care and support was not arranged to ensure people received visits at consistent times. This posed a risk to people particularly where they required regular pressure relief or medicines at specific times.

A range of risk assessments were in place to help support safe care and support. For example detailed manual handling risk assessments to aid staff in the safe transferring of people.

Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable people.

People and relatives we spoke with said they felt safe from abuse in the company of staff. The registered manager followed local safeguarding procedures and where incidents had occurred preventative measures had been put in place to prevent a re-occurrence.

People and their relatives generally said staff had a good level of skill and knowledge and conducted all required tasks in a competent manner at each visit. The service had a strong focus on ensuring it employed experienced staff who then undertook extensive training. Training was kept up-to-date and staff praised its effectiveness in Giving them the skills they needed to carry out their duties. Staff were supported with periodic observations, supervision and appraisal.

The service was acting within the legal framework of the Mental Capacity Act. People were given sufficient choices in relation to their care and support.

People and their relatives described staff as kind and caring and said they had the right personal attributes to ensure dignified care. The attitude of staff was regularly monitored and dignity and respect promoted with staff to help ensure a caring culture within the service.

People's needs were assessed when they started using the service and plans of care put in place. We found some care plans required further detail, for example regarding pressure area care and nutrition.

Call times did not meet people's individual needs and preferences. This meant people were not always receiving appropriate care as calls to provide food, continence care and assistance getting in and out of bed were occurring at irregular times.

A system was in place to record and respond to complaints. Most people told us they were satisfied with the service and where they had complained the service had offered to meet with them.

The service had access to a range of staff with specialist skills and knowledge to help continually improve the quality of care for example to improve clinical awareness. The provider was committed to further improvement of the service and had action plans in place to drive this improvement.

A range of audits and checks was undertaken by the provider. We saw some of these for example medication chart audits and daily record audits had been effective in addressing inconsistencies in documentation. However there was a lack of audits and monitoring to check t staff arrived consistently, and at an appropriate time each day.

We found three breaches of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always offered at the times people needed them and there was not a complete record of the medicine support people were provided with. Call times were not always conducive of safe care.

Risks to people's health and safety such as the risks associated with moving and handling were thoroughly assessed.

Safe recruitment procedures were in place to ensure staff were of suitable character to work with vulnerable adults.

Is the service effective?

Good

The service was effective.

People and their relatives told us staff were appropriately skilled. The service had a strong focus on ensuring staff were provided with a range of training, and support to ensure continuous development of their knowledge, competency and skills.

The service was acting within the legal framework of the Mental Capacity Act. People were given sufficient choices in relation to their care and support.

The service liaised with a range of health professionals to help ensure people's healthcare needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were kind and caring and treated them with a high level of dignity and respect. Systems were in place to monitor and promote dignified care and support.

The service regularly listened to people on a daily basis and offered them choice with regards to their daily lives.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's needs were assessed prior to using the service and changes to people's care and support package made when required.

Call times were not consistent and were not conducive to person centred care and support. People's health and welfare needs were not always met due to inconsistent call times.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Audits and checks did not monitor the appropriateness of visit times. We found visit times were not always conducive to safe and responsive care.

Staff performance and quality was robustly monitored through a variety of mechanisms. The service sought feedback on the quality of its service from people who used the service.

Routes Healthcare Yorkshire

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 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 between 11 and 15 February 2016 and 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 in. The inspection team consisted of one inspector.

We used a number of different methods to help us understand the experiences of people who used the service. We spoke with two people who used the service and eight relatives over the telephone to ask them for their views on the service. In addition we spoke with six care workers, the care quality assessor, office staff, the clinical governance lead, the registered manager and the office manager. We looked at a number of people's care records and other records which related to the management of the service such as training records and policies and procedures.

We asked the provider to complete a Provider Information Return (PIR). 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. This was completed and returned to us in a prompt manner. Prior to the inspection, we reviewed all information we held about the provider and contacted the local authority and local clinical commissioning groups to ask for their views on the service.

Requires Improvement

Is the service safe?

Our findings

Staff had received training in the management of medicines. This was complimented by competency tests to help ensure they had the correct skills and knowledge to administer safely.

We looked at the medicine management system. The service provided support with medicines to a small number of people. Medicine Administration Records (MAR) where in place. These ran on a weekly rather than monthly basis to allow staff to bring MAR's back to the office more frequently. This allowed more frequent checks for any errors or unsafe administration. We looked at medication audits and saw they were routinely identifying issues and actions put in place to reduce the likelihood of a re-occurrence.

In most cases, MAR's showed people consistently received their medicine from day to day. Staff we spoke with had a good understanding of how to ensure people received appropriate medication support.

The service kept a list of the medicines each person was supported with, regularly liaising with the local pharmacy to ensure it was kept up-to-date. Some people had their medicines provided by the pharmacy in dosette boxes. These are boxes that contain medications organised into compartments by day and time, to simplify the taking and administration of medications. However where staff were supporting people with medicines of this type it was written "dosette box" onto the MAR rather than the individual components listed. Although the service kept a list of the medicines people were supported with, this was a separate sheet. We were unable to reconcile the exact support staff provided at each visit as the list did not say at which visit each medicine should be provided.. This meant there was no clear audit trail of the exact nature of the medication support at each visit.

The Royal Pharmaceutical Society guidance on the management of medicines in social care states that when care is provided in the person's own home, the care provider must accurately record the medicines that care staff have supported the person to take.

Where people received "as required" medicines, there were no protocols in place guiding staff when to offer these medicines. This meant there was a risk of inconsistent care and support.

We found the timeliness of some calls was not conducive to safe medicines support. For example we looked at one person's MAR which showed they were prescribed paracetamol, to be supported by staff to take up to four times a day. However the gap between care visits were sometimes less than two hours. Records showed that on one occasion in February 2016 staff arrived at 10am for the first visit of the day and then 12pm for the second visit, a gap of only two hours and on another occasion the first visit took place at 10.20 and the second visit at 11.30. Although staff had recognised that it was unsafe for the person to have doses that close together and had ensured it was not given on these occasions, the way the visits were planned meant the person did not have the opportunity to have their pain relief at safe intervals. In addition the person was prescribed eye drops to take four times a day. The gaps between administration by staff were not conducive to ensuring these were given at reasonably timed intervals throughout the day.

We received mixed feedback about the timeliness of medication calls. For example one person told us "I am very happy with the medicine support I get. I need four hours in-between my tablets and the staff have made sure they are leaving four hours." However another relative raised a concern with us that care visits were supposed to be planned to ensure four hours between medicines but staff had not been on time and sometimes it had been just two hours between medicines. This confirmed the concerns we noted when viewing the medication records.

Nine out of ten people and their relatives told us they were not aware of any calls being missed. However one person said there had been a number of missed calls. We looked at this person's daily records for two weeks in February 2016. On two occasions there were gaps in the daily records where no calls were recorded. By one of these it showed the person's relative had complained of a missed call.

Call times were not always conducive to safe care. For example one relative raised concerns with us that the timeliness of calls was not conducive to safe skin care. They said the service was not taking care to work in conjunction with the night-time care provider to ensure four hourly pressure relief was provided across the six visits that their relative received. We looked at this person's commissioning assessment which confirmed the person required regular positional changes at four hour intervals to protect their skin integrity. It stated they were at very high risk of their skin breaking down. However this specific detail had not been transferred into the persons care plan and there was no mention of co-ordinating visit times to work with the night time care provider to ensure six visits at four hour intervals. We looked at this person's daily records for a week in February 2016. These showed erratic and inconsistent call times. For example the teatime call had varied between 15.30 and 18.15 and the evening call between 18.55 and 21.35. This had resulted in inconsistent gaps between pressure relief. For example it had varied between 2 hours 40 minutes and 6 hours 25 minutes between the lunchtime and early evening calls and between 2 hours 20 minutes and 6 hours and five minutes between the teatime and evening calls.

Following the inspection, the provider immediately took action to improve consistency and met with people and their relatives to help ensure improvement.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities Regulations 2014).

Records showed where two staff were required for moving and handling these was always achieved, through the creation of double up runs where staff travelled together. People and relatives told us that where required two staff always turned up.

People and relatives told us they thought people who used the service were safe from abuse. They said staff were kind and treated them well. For example one person told us "The carers have made me feel safe." Staff we spoke with did not raise any concerns with us about people's safety and they understood how to identify and act on allegations of abuse. The registered manager worked to the West Yorkshire Safeguarding Adults Policies and Procedures and we saw evidence these had been followed to help people safe. Where staff thought people were left in unsafe conditions, we saw referrals had been raised with the local authority. Where safety related incidents had occurred within the service, appropriate action had been taken to investigate and help prevent a re-occurrence for example in providing staff with additional training.

Although we found rota's were not effectively managed to ensure people received consistent call times, we concluded the service had sufficient staff deployed. We looked at rota's and saw they were not overly burdensome on staff. Calls were arranged into three community runs to help ensure consistency of care workers. Staff we spoke with told us they thought there were enough staff and that they did not feel

pressured into working longer hours. The provider also ran a recruitment agency providing care workers to other businesses. This gave the service a larger bank of staff to call upon to ensure sufficient staff were available to cover sickness and holidays. The registered manager demonstrated to us that the service thought carefully about taking on new care packages, based on the staff available and rejected them if they thought they did not have sufficient staff. This helped ensure there were sufficient staff available to meet people's individual needs. A range of office staff were also available to answer the phone, undertake administration and care management tasks.

Safe recruitment procedures were in place. This included ensuring people completed an application form detailing their previous employment and qualifications. Any gaps in employment were robustly investigation. A thorough selection process was in place which included pre-screening over the telephone and then suitable candidates were invited to face to face interviews. Only candidates with a minimum of six months experience in care could progress in the selection process which helped ensure staff had the necessary experience to care for the client group. We looked at interview questions which showed the service only took on people who could provide competent answers to a number of critical subjects such as safeguarding, moving and handling, and commitment to further professional development and end of life care. Sufficient checks on people's backgrounds took place including ensuring a Disclosure and Barring Service (DBS) check and references and identity checks were undertaken. Staff we spoke with confirmed when they were recruited the required checks had been undertaken.

Risks to people's health and safety associated with moving and handling and the environment they lived within were thoroughly assessed by the service prior to delivering care and support. Staff were supported by the Care Quality Assessor who had recognised training qualifications in health and safety and manual handling to offer expertise and input particularly in complex assessments. We looked at a sample of these assessments which showed a good level of detail recorded. People and their relatives told us staff supported them safely in moving and handling and in maintaining a safe environment. Where other risks such as choking were identified, clear plans of care were put in place.

Good

Is the service effective?

Our findings

Effective systems were in place to ensure staff had the right skills and knowledge to care for people. People and their relatives spoke positively about the skills and knowledge of staff. They said staff were helpful on delivered care competently. Staff we spoke with demonstrated a good awareness of the topics we asked them about. They all told us training and support was very good within the service. We concluded staff received an excellent range of training. New staff were supported to complete the care certificate. The service had worked in conjunction with Skills for Care to produce a bespoke training and assessment package tailed to new staff's needs. This included the completion of three writing tasks, with completion of the care certificate taking place over a longer time period of up to a year to help embed knowledge and practice. New staff received regular observations of practice and clients were asked to complete a quality questionnaire to ensure they were happy with the skills and knowledge of new staff.

The service had its own training room with a range of equipment which included a bed, hoist and commodes. This allowed staff to receive in house updates in manual handling training which was delivered by staff with recognised training qualifications. Face to face training in first aid and medication was also provided to staff. This was complimented by a range of e-learning in topics such as dementia awareness, the Mental Capacity Act and safeguarding. All staff were up-to-date with all mandatory training. Staff were not permitted to work shifts if any of their training had expired. This demonstrated a strong commitment to ensuring staff were up-to-date with training.

Staff had access to a range of specialist training included Percutaneous endoscopic gastrostomy (PEG), autism and tracheostomy. Management and staff were clear they would not deliver care to anyone with specialist equipment or needs without first receiving training in the subject. The service was committed to continuous improvement of its training provision for example it had highlighted the need to provide additional end of life training to staff and this was being completed by staff.

Staff received regular supervision and appraisal. Following each appraisal the service worked with staff to put an action plan in place to promote continuous improvement of practice and professional development. Staff were encouraged to achieve recognised national qualifications in health and social care.

The clinical governance manager, a registered nurse also ran 'pop in sessions' to assist staff with any clinical queries and help improve care and support practice. This was a good mechanism to help ensure effective care and provide support in dealing with any complex needs.

We saw the service liaised with external health professionals such as doctors and district nurses. This helped to ensure people's healthcare needs were met. We saw conversations with health professionals was robustly documented within care files so staff were aware of any contact. We spoke with one health professional about the service who said they were not aware of any issues or concerns with their patients who used the service.

People and their relatives told us the service supported people appropriately with food and drink. For

example one person told us "Yes they always make sure I have something to eat and drink," Nutritional care plans were in place. These provided detail on the support required, however we found these could have contained more detail about people's nutritional support needs. Daily records we reviewed provided evidence that people were provided with a range of food and offered a choice at each care visit. One relative told us "They ask what she wants and then provide it."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. In the case of Domiciliary Care applications must be made to the Court of Protection. The service had not needed to make any applications to the Court of Protection. We found the service was working within the principles of the MCA. People's capacity was assessed as part of the care planning process. People signed to agree to their plans of care and we saw evidence in daily records of care that people were asked for their choices with regards to how they wanted their care and support tasks to be delivered. The registered manager was developing the consent form further to ensure it provided better evidence that where people lacked capacity decisions were made in their best interests.

Good

Is the service caring?

Our findings

People and their relatives all told us that staff were kind and caring and treated them well. One person who used the service told us "I have only been using them a week, but already my anxiety and stress has been reduced. The carers are all so good and efficient, they are so caring." Another person told us "Care staff are brilliant." A relative told us "No problems, all really pleasant and get on with their job, all friendly. The carers personal skills and absolutely fantastic."
Another relative told us "Really helpful, really polite they do everything they can to support [relative] and a third relative told us "Lovely girls, very friendly with her, she is happy with them."

The recruitment and induction process had a strong focus on ensuring staff delivering care had the right personal attributes to provide dignified care. There was a strong focus on the importance of personalised care and support. The manager was a dignity champion for the service responsible for promoting a high level of dignity and respect amongst staff. Observations of staff practice looked at the attitude of staff, if they offered people choice and if people's privacy and dignity was maintained. This helped promote a caring culture within the organisation. We looked at a selection of observation records which showed staff had scored highly and had been assessed as being very caring towards people who used the service.

Staff we spoke with demonstrated a dedication to providing a caring and dignified service and were aware of how to promote choice and offer people dignified care.

People and their relatives told us staff engaged people in conversation as well as completing care and support tasks. The registered manager told us the service did not accept referrals for 15 minute calls as they felt they could not complete the required care and support and ensure the required social interaction within that time period. The minimum call time was 30 minutes which allowed staff to develop a better relationship with people who used the service and allowed care to be delivered in a more relaxed and less rushed atmosphere.

Visits were organised into runs to help improve consistency with regards to the people who attended calls. Most people we spoke with told us that on the whole they had the same group of carers. However a couple of people told us they wished there could be more consistency with regards to the care workers who visited.

Staff we spoke with demonstrated a good understanding of the people we asked them about and how to ensure compassionate care was provided, for example to those living with dementia. Care records contained information on people's preferences and some limited information on their life history.

People told us they felt listened to by the service. We saw people's views were regularly sought through periodic contact with the office over the telephone and through visits when management picked up paperwork from houses. We saw these were done frequently, and people's comments and suggestions logged. One relative told us "We are always kept informed if something is going on." People and relatives told us they could get in touch with the office and found staff in the office also to be kind and helpful. Care

records we reviewed showed evidence that people were listened to on a daily basis and given choices with regards to their daily lives.

People and their relatives told us they thought staff had the right personal attributes to ensure appropriate end of life care was provided. We saw the staff recruitment, training and support process focused on ensuring that dignified end of life care was provided.

Requires Improvement

Is the service responsive?

Our findings

People did not receive fully personalised care that met their needs as visit times were not always consistent and showed unacceptable variation from day to day. Three of the ten people or relatives we spoke with told us that they were unhappy with the times care staff visited with a further two raising call times as a minor issue. Comments included "Time of care staff is main issue "and "Brilliant so far, timeliness is the only downside, it would be nice if they came at the same time each day."

We looked at six sets of care records which showed a lack of consistency to visit times. This meant that people were not being offered consistent support with continence, meal preparation, medicines and other support at consistent times each day impacting on their health and welfare. It demonstrated that appropriate person centred care that met people's individual needs was not being provided. For example on reviewing one person's records between 26 January 2016 and 8 February 2016 we saw the person received morning calls between 08.30 and 12.05 with significant variation from day to day. Another person's records showed morning calls took place between 06.55 and 09.50 during a period of days in late January 2016 with significant variation from day to day.

One relative told us "Care staff brilliant, care is good but timing is all over the place. " They stated that care staff were supposed to arrive at 7am to ensure appropriate pressure relief was provided but this had been as late as 10.30am. They stated staff were often 1.5 hours late. They said they were concerned about the impact this had on their relatives' health and welfare. We looked at this person's records which showed an unacceptable level of variation for example early evening calls took place between 15.30 and 18.15.

Another person told us "Girls are absolutely lovely, but not got regular times". Morning call can be anything up to 11am. Odd times they have missed the teatime call and gone to bed at 8." In the morning the bed is wet through when they are late." We looked at the person's records which confirmed the erratic nature of call times with the person's morning call had varied between 7.30am and 10.30 in a two week period in February 2016. The records indicated there had been two occasions care where visits had been missed in a two week period in February 2016.

This showed these people were not receiving person centred care that met their individual needs.

This was a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People's needs were assessed by the service prior to service delivery to help ensure responsive care that met people's needs was put in place. One person told us "Had a very thorough process which made me feel at ease, they have been back already to check everything is running well." Information on people's medical history, key contacts and length of call was obtained to help provide appropriate care. Brief information on people's history was present to help staff deliver appropriate care. A range of care plans were put in place which included maintaining a safe environment, communication, breathing, hygiene and nutrition, continence. We found some care plans required more detail to evidence a person centred approach to care

and support. For example daily records showed another person had a catheter in situ with staff required to provide regular catheter care, however the continence assessment did not mention that the person had a catheter. We saw the service had identified similar issues through its internal systems of audit and set up a care plan development group. There were plans to the develop care plans further and introduce a number of specialist care plans.

Most people and their relatives said they were pleased with the standard of care provided when the staff visited. They said when staff arrived they stayed for the correct amount of time and completed all required tasks to a high standard. They described staff as "brilliant" "bright and cheerful" and "on top of things." Staff we spoke with demonstrated a good understanding of their role and the tasks they needed to complete to meet people's individual needs.

Periodic staff meetings took place. Care delivery was discussed at these and they were a forum for making any changes to service delivery to ensure they responded to people's changing needs. People's care packages were regularly reviewed and people and relatives we spoke with said generally they felt involved in the care review process. For example one relative told us "Very good, always keep us informed of what's going on." People and their relatives and records showed us people were asked for their feedback on a regular basis. Where people's conditions changed, we saw evidence staff identified this and liaised with visiting health professionals.

A complaints policy was in place and it was brought to the attention of people who used the service through the service user guide. We saw where concerns had been raised; the service had met with people to discuss these concerns and made efforts to resolve them. Most people and relatives we spoke with told us they thought the manager and staff listened to them and tried to address any concerns raised. We saw evidence prompt action had been taken to address complaints and make improvements for example through providing additional training to care staff or changing the carers who supported people. However where late calls had been recorded this was not being routinely logged as a complaint.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place. We found all required statutory notifications had been reported to the Commission. This meant we could effectively monitor events occurring within the service.

People provided mixed views about the quality of the service. Most people and relatives praised the service for example one relative told us "Brilliant so far." Seven out of 10 people or relatives we spoke with told us they were satisfied with the service and told us it provided high quality care. However three relatives told us they were not satisfied with the service as they had concerns over visit times.

Some staff told us they did not always follow the order of the rota's as they did not always make geographic sense or they recognised that following the order on the rota would result in visit times that did not meet people's individual needs. One staff member told us that they had been told by the office that the rota's were "just a guide". However this lack of compliance with rota's led to erratic and inconsistent call times. Some staff whilst saying they enjoyed working for the service said that rota's needed better planning with someone with local knowledge of the area. One relative also told us this was the case stating "It needs someone with a local knowledge because the office is in Bradford to plan the rounds in Halifax". Staff said they were happy with the care the service provided. One staff member told us "Timeliness is the only thing, I know clients would be happy if that was addressed."

Audits and checks on medication and care records failed to monitor the timeliness of care delivery or check that visit times promoted safe care and welfare. For example checks on medication records had failed to identify that visit times were not conducive to safe medication support. Checks on daily records whilst identifying documentation issues had failed to identify the unacceptable variation in call times that we found. However people required care and support and consistent visit times to ensure their needs in areas such as continence, daily routines, mealtimes and medication were met. Following the inspection the provider told us they had taken this feedback on board and incorporated visit times into their audits and checks.

Although we found daily records were in the most part consistently completed with a good level of detail and staff detailing the time of visit this was not always the case. One relative complained to us of a very late call time on a morning in February 2016. When we viewed the person's daily records there was no call time recorded. We therefore could not confirm the time this call took place due to lack of appropriate records.

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

The service had only been delivering personal care since July 2015 so had not yet undertaken a full quality audit of its systems and processes. However the registered manager and area manager told us this was planned for later in the year.

We saw a number of systems of audit were in place to help assess, monitor and improve the service.

Recruitment files were regularly audited and the provision of training was robustly monitored to ensure people received training and support which met their individual needs and to ensure training did not expire. We saw where these audits took place and items were identified they were followed up for example with additional training. Staff appraisals took place and actions were assigned to staff to help drive improvement which included considering training needs.

Systems were in place to bring community based documentation back to the office for review by management. Medication charts were brought back to the office and were audited to ensure the required signatures had been provided. Daily records were also regularly audited to ensure staff were consistently recording the required information. We saw evidence both of these audits had been effective in identifying issues such as record keeping for example on MAR charts.

Staff received periodic spot checks and observations of their practice. These looked at range of quality indicators, including staff appearance, attitude and care competence. This helped ensure a consistent quality of care and drive continuous improvement. During observations of practice, where staff had exceeded expectations, they were sent a formal letter by the organisation. For example we looked at one where the staff member had been identified as being "very caring" and completed documentation to "a very high standard." This helped ensure staff felt recognised and valued for their hard work and helped promote a positive culture within the organisation.

The organisation had a clear structure in place which allowed expertise to be shared around the organisation. For example a training manager and care quality assessor provided training and risk assessment expertise and the service was overseen by an operations manager. The service had recently appointed a clinical governance manager. We saw evidence they had undertaken initial audit work and put in place an action plan to drive continuous improvement within the service. They had recently chaired a care plan focus group to help achieve further improvements to care plan documentation, for example to ensure care plans were in place to help manage specific conditions people had such as diabetes, epilepsy, nebulisers and end of life.

People and relatives we spoke with, although they were not all completely satisfied with the service, told us that the service had offered to meet them and listen to their views. We saw evidence of this in the records we reviewed. This demonstrated the service was committed to listening to people to help ensure further improvement.

Incidents and accidents were recorded either in the accident book, or on a dedicated form for other types of incidents for example medication recording errors. However, although medication recording errors were fully investigated there was no central collation of medication errors to look for any trends or themes. The registered manager had recognised this was a shortfall and told us they had plans in place to address.

Periodic staff meetings took place. We saw these were an opportunity to discuss care and treatment and improve care and support.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care 9 (1 a&b) The care and treatment of service users was not appropriate and did not meet their individual needs as call times did not consistently meet people's needs.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment 12 (1) (2b) (2g) Care and treatment was not provided in a safe way to service users as the service was not doing all that is reasonably practicable to mitigate risks to people's health and safety. Medicines were not always managed in a proper and safe way.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance 17 (1) (2a) (2c) Systems were not fully in place to assess, monitor and improve the service. An accurate, complete and contemporaneous record in respect of each service user was not maintained .