J.C.Michael Groups Ltd

J.C.Michael Groups Ltd Hackney

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

Summary of findings

Overall summary

The inspection took place on 13 and 14 September 2018 and was announced. This was the service's first inspection since they registered with us in August 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own homes and flats in the community. It provides a service to adults with support needs including older people, people with physical disabilities, people with mental health conditions and people with learning disabilities. At the time of our inspection they were providing care to 114 people. Not everyone using the service receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

There was a registered manager in post. 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 told us they felt safe with their care workers. The provider acknowledged they needed to update care plans and risk assessments to ensure they contained sufficient information about how to mitigate risk and support people with their medicines. They started this process during the inspection.

People received care from regular care workers who were recruited in a way that ensured they were suitable to work in a care setting. The staff scheduling meant people did not always receive care at the time it had been scheduled. We have made a recommendation about staff deployment.

Staff were knowledgeable about safeguarding adults from harm and knew how to escalate any concerns they had. Incidents were investigated and action was taken to ensure incidents were not repeated.

People were involved in writing and updating their care plans. Records showed people received the care they needed. People were supported to access healthcare services and received the support they needed to maintain their health. Care workers supported people to eat and drink enough to maintain adequate nutrition and hydration.

People consented to their care, and were offered choices. Where people lacked capacity to consent to their care and treatment the service applied the principles of the Mental Capacity Act 2005.

Staff demonstrated a compassionate approach and attitude to supporting people. They spoke about upholding people's dignity and treating them with respect. The service respected people's cultural and religious backgrounds and the impact this had on their care preferences. The service created a safe space for people to disclose their sexual and gender identity.

People were asked to provide feedback about their experience of care through regular telephone surveys and questionnaires. People knew how to make complaints. Complaints were responded to appropriately and apologies were given when appropriate.

The provider had a policy framework in place to support people at the end of their lives. However, people were not being asked for their views in advance in line with the framework. We have made a recommendation about end of life care.

Staff spoke highly of the registered manager and we saw there was an open and friendly atmosphere in the office. The values of the organisation were clear and on display for staff to refer to. The registered manager completed a range of audits and quality assurance checks. However, the processes to ensure oversight, analysis and improvement were not yet embedded. We have made a recommendation about quality assurance systems.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. People were supported to take medicines but staff did not always have enough information to ensure this was done in a safe way.

Risks to people during care were identified, but staff did not always have clear information about how to mitigate risks.

Staff rotas were not structured in a way that ensured people received care as scheduled.

People felt safe and staff were knowledgeable about how to protect people from avoidable harm and abuse.

Staff were recruited in a way that ensured they were suitable to work in a care setting.

When incidents occurred the provider took action to ensure people were safe.

Is the service effective?

Good

The service was effective. People were involved in planning their care so it reflected their needs and preferences.

Staff received the training and support they needed to perform their roles.

People were supported to eat and drink in line with their preferences.

Staff worked well with other services and healthcare providers to ensure people received the support they needed.

People consented to their care and the service worked in line with the principles of the Mental Capacity Act (2005).

Is the service caring?

Good

The service was caring. Staff had developed trusting, caring relationships with the people they supported.

Staff spoke about how they supported people to uphold their dignity.

The service ensured that people's cultural and religious beliefs were respected.

Staff understood the impact people's sexual and gender identity may have on their experience of care.

Is the service responsive?

Good

The service was responsive. People received personalised care which was reviewed and updated regularly.

People knew how to make complaints, and complaints were responded to appropriately.

The service was not supporting anyone in the last stages of their life. There was a framework in place to ensure people would receive appropriate end of life care if they needed.

Is the service well-led?

Requires Improvement

The service was not always well-led. Systems identifying and addressing issues with the quality and safety of the service were not yet fully embedded.

The registered manager completed a range of audits and took actions at a local level to make improvements.

There was a calm and professional atmosphere in the office and people and staff told us it was easy to speak with the management team.

The provider worked well with other organisations in the local area.

There was a clear values base to the service.

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Detailed findings

Background to this inspection

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

The inspection took place on 13 and 14 September 2018 and was announced. The provider was given 24 hours' notice as they are a domiciliary care service providing care to people in their own homes; we needed to be sure staff would be available to us during the inspection. This was the service's first inspection since they registered with us in August 2017.

Before the inspection we reviewed information we already held about the provider. This included the information provided when they registered as well as notifications submitted to us. Notifications are information about events and incidents providers are required to tell us about by law. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

The inspection was completed by an inspector, an assistant inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. An evidence review officer also attended the inspection as an observer.

During the inspection we spoke with 11 people who used the service and two relatives. We spoke with 10 care workers, the registered manager, a field care supervisor, a care coordinator and the administrator. We reviewed care files for eight people including assessments, care plans, risk assessments and records of care. We reviewed six staff files including recruitment, training and supervision records. We reviewed various documents, meeting records and reports relevant to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us, and care workers and rota information confirmed, they had regular care workers who supported them. A relative said, "Usually it's the same carers during the week. They do send other carers when the regular ones are on holiday, but that is usually on the rota." People told us they were informed if their care workers were running late. Care workers told us they did not feel under pressure to take on additional work, and were given rotas that included travel time. One care worker said, "They always check my schedule before asking if I can do extra work. If one of my regular clients is in hospital they will offer me extra work." Other care workers told us they thought the service had enough staff and they had the time they needed to provide care and support to people.

We reviewed the electronic call monitoring information for six care workers and six people who used the service. These showed people had good continuity seeing regular care workers over the period reviewed. However, they also showed that care workers were not always deployed effectively as care workers were given schedules with simultaneous visits scheduled and no travel time. For example, over a two week period one care worker was scheduled simultaneous visits on four occasions, a second care worker was scheduled simultaneous visits on eight occasions, a third care worker was scheduled simultaneous visits on 13 occasions. In addition, the electronic call monitoring data showed one care worker worked for 31 hours from 11pm on day one to 9pm on day three. The shifts included night shifts and a twelve hour day shift. The care worker had not more than three consecutive rest hours over the course of three days.

We asked the registered manager to respond to our findings. They told us the people had told them continuity of care worker was more important to them than timing of visits, which meant they did not mind if care workers were late, as long as they knew who was coming. They also told us the overnight shifts worked by a care worker were sleeping shifts rather than a waking night, however this was not clear from the electronic records. They were able to explain the circumstances behind late visits recorded.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring effective scheduling and deployment of staff in domiciliary care.

People told us staff supported them to take their medicines. Care workers described safe administration practices and told us how they ensured they were administering the medicines people had been prescribed. Supervisory staff and care workers who had been assessed as competent updated records to ensure the information the provider held about people's medicines was correct. The provider recognised that the medicines people were prescribed could change regularly and it was important they had the correct information in their systems. Records showed staff supported people to take their medicines as prescribed.

Although staff knew where to find information about what medicines people had been prescribed, they did not have access to information about the purpose of medicines. The information about the actual support people required to ensure they were supported to take their medicines was lacking. For example, it was not clear if staff provided verbal instructions or physical assistance to people with their medicines. The registered manager was signposted to the best practice guidance for supporting people with medicines in

home care.

The registered manager recognised their current information did not include detail about the purpose of medicines or the precise nature of the support to be delivered. After the inspection they submitted a new template for medicines information that they will add to their electronic care plans. This contained space to record the information required to ensure staff had all the information required to safely administer medicines. The provider told us they would implement the use of this template and have updated information within three months. We will monitor the provider's progress and follow up on this at our next planned inspection.

The provider followed robust recruitment practices which ensured staff were suitable to work in a care setting. Staff files included information about staff members employment history, with references collected to ensure they were of a suitable character. The interview process assessed staff attitude and competence against set criteria which reflected the values of the provider. The provider completed checks of staff backgrounds and criminal records to ensure they were suitable to work in a care setting.

People and relatives told us they felt safe with their care workers and were confident they would know how to respond to an emergency situation. One person told us, "If there was an emergency I know they [the care workers] will call my son and an ambulance at the same time. They will keep in touch with my son for updates." Staff were confident in how they would respond to allegations of abuse. One staff member said, "I'd do a report straight away." Other staff described how they would offer reassurances and comfort to people and ensure the provider took action to ensure people were safe. Care workers were confident about how to escalate concerns if they were not satisfied with the initial response of their managers. One care worker said, "If the office didn't take it seriously then it becomes whistleblowing. I keep going up the chain until someone listens."

Records showed the provider took appropriate action when allegations of abuse were made. There was a comprehensive record of the actions taken and the provider raised concerns with the local authority appropriately. Information about how to contact the local safeguarding team was prominently displayed in the office. Records showed staff discussed safeguarding practice in supervision meetings and staff meetings which helped to ensure people were safeguarded from abuse and avoidable harm.

People told us they were confident staff knew how to support them in a safe way. Some people required the use of equipment and aids to help them mobilise and stay safe in their homes. One person said they were confident staff knew how to support them to use their equipment safely. They said, "I'm housebound and there are lots of aids that I have to use. The carers are very good, they know how to use them. I'm so lucky at my age to have them looking after me." Care records showed the provider had identified where people faced risks during the receipt of care, for example in the use of equipment or due to health conditions.

When we initially reviewed risk assessments they were limited in the information they included about how to mitigate risks. This was discussed with the registered manager who recognised the risk assessments did not provide all the information a care worker would need to support people in a safe way. After the inspection the registered manager submitted an updated care file which included more detail about how to mitigate risks, and clearer directions about where information about risk could be found. For example, one person required support with exercises to mitigate the risk of their limbs stiffening. As these exercises changed regularly care workers were directed where to find the most up to date guidance in the person's home. The registered manager told us it would take three months to fully update all the risk assessments in the service. We will monitor their progress and check they have done this when we next inspect the service.

People and relatives told us care workers wore gloves and appropriate personal protective equipment while supporting them. They confirmed care workers washed their hands regularly. Staff told us they were supplied with sufficient personal protective equipment to mitigate the risks of the spread of infection. Care files contained specific risk assessments where people were identified as being particularly vulnerable to the risk of infection. This meant staff had clear information and reminders about how to minimise these risks and keep people safe.

Incident reports showed staff were confident to raise concerns with office based staff. We saw staff telephoned and visited the office to discuss any concerns they had. Where these concerns were identified as being incidents staff completed a written record to ensure management had enough information to investigate and take actions to ensure people were safe. Records showed the provider liaised with people, their relatives and other services appropriately following the reporting of an incident. Where necessary care plans were updated and this was communicated to staff teams working with people. This meant the service responded positively to incidents and ensured lessons were learnt and shared.

Good

Is the service effective?

Our findings

People and relatives told us they met with the provider before they started receiving a service. The field care supervisor visited people in their homes to complete the initial assessment of their needs following a referral from the local authority. We saw the provider had robust systems in place to manage the referrals process in a way that ensured people received a service that met their needs. The provider matched people with care workers on a long-term basis giving care workers a stable rota and people a core team of care workers who got to know them well. The provider did not accept referrals for packages due to start over the weekend, or at very short notice as they could not guarantee staff availability to work with people during their first experience of the care service. Records showed the provider had not accepted referrals during a recent religious festival as many of their care workers were observing the religious festival they did not have capacity to take on new packages of care.

The provider had introduced electronic care records and the field care supervisor was able to complete assessments directly into the systems using a tablet computer. Assessments included a breakdown of the tasks that needed to be completed, as well as information about the risks to people and care workers that might be present. All assessments included an environment risk assessment for both the person's home and surrounding neighbourhood. The assessment also included a breakdown of the schedule of care and the individual goals and desired outcome of the support package.

People were able to schedule their care at different times depending on the day of the week. We saw some people choose to schedule their care earlier on weekends so they could attend their place of worship. Care workers confirmed this flexibility. One care worker said, "On Sundays I start very early. It's important for the ladies that they have time to get ready properly before they go to [place of worship]. They want to wear their particular dresses so I go early so they are ready in time."

The assessment process explored people's preferences for care tasks and ensured this information was available to care workers in the care plan. For example, it was specified what temperature people liked their showers to be set. Another care plan specified the person wished to have a shower on certain days but a wash on others. The care plans ensured staff had the information they needed to meet people's needs. In conversation with care workers they were all able to give detailed information about the preferences of the people they supported. We noted their knowledge was much more detailed than the information captured in the care plans. The registered manager recognised this and has committed to ensuring the detail of people's care preferences, as well as care tasks, will be included in care plans as they are reviewed and updated.

Staff told us they received the training and support they needed to do their jobs. One care worker explained, "The training and induction are intense, they set you up to be a good carer." Another care worker said, "I've had the training I need. If someone gets a new piece of equipment, they will make sure we get the training on it. I've just had training on a new kind of sliding sheet that uses a remote control." A third care worker said, "The training is good. They adjust it too, so they could see I was an experienced care worker so I didn't do so much shadowing, but [colleague] who hadn't worked in care before got more shadowing to make sure

they were confident."

Records showed staff completed annual training in areas relevant to their role. This included the topics of the care certificate. The care certificate is a nationally recognised qualification covering topics to give care workers the foundational knowledge required to work in the care sector. The provider kept records and was able to see where staff had not yet completed their annual training. They identified the reasons for this, and staff were booked to complete their training. Care workers received supervision every three months. Supervision records showed staff confirmed they were aware of the provider's policies and procedures and discussions were recorded around their understanding of aspects of their role. Staff were given the opportunity to talk about the people they supported and we saw any concerns raised were escalated and dealt with appropriately.

People told us care workers supported them with meals where this was part of their care package. People told us care workers supported them to warm prepared meals and ensured they had drinks available. Care plans included information about people's dietary needs and preferences. Records of care showed people were supported to eat and drink in accordance with their preferences. Some people who received care were identified as being at risk of malnutrition, or were unable to eat safely. Care plans included guidance for staff on how to ensure people received sufficient nutritional intake. The provider's systems allowed for detailed recording of dietary intake where people's risks required this.

Care workers told us they worked with other services and organisations involved in people's care. For example, one care worker described how they worked with the person's physiotherapist and occupational therapist to ensure the person received the support they needed. Records showed the provider worked closely with day services involved in providing care to people. For example, we saw one person attended a day centre each day, but there were contingency arrangements in place to ensure the person received additional support from the provider if they were unwell and unable to attend the day centre. Contact details for other professionals were available within care files. During the inspection we saw staff coordinated visits to ensure care workers were present when other professionals visited people which meant information was shared effectively.

People received support to manage long-term health conditions. Care plans contained guidance for staff on how to respond to health related emergencies such as seizures. For each health condition a person lived with, their care plan contained a summary of the impact this had on their lives. For example, if the person lived with a condition which caused pain, or affected their memory, this was available for staff. Where it was included as part of the package of care, care workers supported people to attend health appointments. Care workers told us they would support people to make appointments and liaise with family members if people appeared unwell during visits. One care worker said, "If someone seemed unwell I'd speak to their family if they were there, or call them up. I'd make sure they knew. If they don't have family we speak with the office, and call the doctor if they need 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.

We checked whether the service was working within the principles of the MCA and found that it was. The provider ensured they collected information about people's capacity to consent to their care and treatment. Where people had legally appointed decision makers in place the provider took steps to ensure they had the

correct information about who had authority to make different types of decision. We identified the provider had confused the different types of authorisations that are possible and the registered manager took steps to clarify their templates during the inspection.

People and relatives told us they were involved in making decisions and were asked permission before care tasks were completed. Care workers told us they offered people choices in a way that facilitated decision making. For example, one care worker described how the person they supported could choose from two items of clothing if they were shown them, but not if they were asked about them verbally. Where it was appropriate, care plans contained details of how to support people to make choices and how to interpret their behaviour as communication.

Good

Is the service caring?

Our findings

People told us their care workers were kind and engaged with them. One person said, "They [the care workers] are willing to do this and have a good sense of humour. I have a very god rapport with them. We have social chats about life experiences. They are very helpful and will have a birthday celebration drink with me, but they only have a soft drink. They never over step the boundaries." During the inspection we saw one care worker seeking advice from the registered manager about supporting one person to access community and social activities as part of their support. The person had asked to go to the pub and the care worker wanted to check this was appropriate. The registered manager reassured the care worker this was the person's choice and the care worker demonstrated an understanding of appropriate professional boundaries.

Care workers described how they build up relationships with the people they supported. They demonstrated they understood the importance of gaining the trust of the people they supported, particularly as the nature of their role meant they were often supporting people with intimate tasks soon after meeting them. One care worker explained, "When I visit someone for the first time we have a little chat first and I explain my role. If they haven't had care before that's very important. I do what I can to make them feel more comfortable and confident to trust me."

Care workers were particularly sensitive to the embarrassment people may feel when they needed support with personal hygiene tasks. One care worker said, "I work with one person who gets so embarrassed and worried about it. I try to reassure them that it's not a problem or an issue for me. I try to reassure them we know it's not their fault or choice." Another care worker said, "It's important we work joyfully and kindly. Some people can be very shy and maybe upset. It's not their fault and we try to make sure they know that. We wouldn't ever cover our noses or talk about it. If I ever saw another carer do that I know [registered manager] would be on the case."

Other care workers gave examples of how their practice upheld people's dignity, for example, by ensuring they remained covered during personal care, or that other members of the household were asked to leave the room during care.

The provider collected information about people's religious beliefs as part of the care planning and assessment process. Care workers demonstrated they understood that people's beliefs and cultural background affected their care preferences. One care worker told us, "One person I support is very strict about no shoes in the house. We have shoe covers, but when it is religious festivals they prefer no shoes at all. I always make sure I'm wearing my good socks when I go to their house." Another care worker said, "A lady I support asked me to come early because she was going [to attend religious event], of course we did. Her family were there too and they all looked stunning when they left the house."

Care workers told us they knew about the significant relationships in people's lives. One care worker told us they found it helped engage the person they supported when they spoke about their partner. None of the care workers we spoke with told us they supported anyone who identified as lesbian, gay, bisexual or

transgender. However, they demonstrated they understood that people's sexual and gender identity could affect their experience of care. One care worker explained, "There's no one [who identifies as LGBT] that I know of. We respect who they are. I am their carer to meet their needs, it's not for me to judge." Another care worker said, "You have to respect all aspects of people's lives. Treat everyone equally, person-centred care is personalised, I'll work how each person wants me to." A third care worker said, "I understand some people might be nervous about carers knowing their personal lives, but it really makes no odds to me. My job is to support them and hopefully make them comfortable enough to realise that."

Care plans contained details of which aspects of support people could complete independently. Care workers told us they were careful to ensure they did not take over tasks people could do for themselves. One care worker explained, "One person I support likes to do [care task] herself, so she does. Sometimes it takes a bit longer but it's important to her to do it herself."

Good

Is the service responsive?

Our findings

People told us they had regular meetings with staff about their care. One person said, "A lady came yesterday to have a look through it with me." Records showed care plans were living documents that were regularly amended by staff to ensure they reflected people's needs and preferences. Care workers told us they could report changes in people's needs to the office and they would visit people to re-assess their needs and update the care plan. One care worker said, "They [office based staff] are really good for that, they'll come out and do the assessment." The provider was in the process of moving away from paper based records and was using an online electronic platform to write and record care plans. This meant care plans were available to care workers on their mobile phones.

Care plans were divided into the tasks that needed to be completed at each visit, with an additional section detailing information about people's life story, personality and preferences. Care workers told us they contained enough detail so they could support people to have their needs met. We noted that some details of people's preferences were not captured which would mean a new care worker may have to seek further information to be able to meet people's needs fully. For example, the plans did not contain details of how often people wished to be supported to wash their hair. The registered manager took on board this feedback and showed us an updated care plan with more details and an action plan for updating all care plans to this standard.

People told us care workers recorded their visits in books held in their home. The provider told us they were in the process of moving over to electronic records. Care workers who were confident and assessed as competent by the registered manager were recording visits electronically while other staff were using paper records until they were trained and assessed as competent. Records showed care workers captured the support they provided and commented on the person's wellbeing. We saw care workers escalated any concerns and information about changes in people's needs was handed over between care workers. The provider was in the process of arranging for family members to be able to access the electronic care records so they could be assured their relative had received care as agreed.

People were given a copy of the complaints policy when they started to receive a service. People confirmed they knew how to make complaints and provide feedback. One person said, "I've not had to pull them up on anything, but I know who to call if I did." Records showed the provider considered any negative feedback received through routine monitoring as complaints, as well as issues raised using the complaints process. The provider investigated and responded to complaints in line with the timescales set out in their policy. The provider offered apologies and took actions to ensure the circumstances that led to complaints would not recur.

People and their relatives were regularly asked for feedback about the service they received. Staff would call people and relatives once a month to complete a survey which considered people's experiences. We saw management had identified they had got behind in their schedule of collecting feedback and the provider's head office had completed feedback interviews to ensure they had feedback about people's experiences.

At the time of our inspection the registered manager told us the service was not supporting anyone who was in the last stages of their life and receiving end of life care. The registered manager told us they would ensure important information, such as the contact details of healthcare professionals and whether or not the person wished to be resuscitated would be included in the care plan summary and task visits to make sure this information was available to care workers. The provider had a policy in place regarding end of life care which emphasised the importance of collecting information about people's views and preferences in advance, and working with end of life healthcare services in the community. The assessment framework and care plans in place did not include information about whether people had been asked about their end of life wishes. The registered manager told us they would speak with their electronic care plan provider to add a section about this onto the system.

We recommend the service seeks and follows best practice guidance from a reputable source about ensuring people are supported to plan for the last stages of their life.

Requires Improvement

Is the service well-led?

Our findings

The provider had a clear mission statement and values base for the service. This was based on supporting people with dignity to live their lives with the support they needed to stay in their own homes. There was a clear commitment to supporting people to uphold their dignity and treat people with respect. This was reflected in the comments from staff about their appreciation of how people may feel about the need to receive care. The provider had signed up to the Social Care Commitment and had information about The Six Cs of caring on display in the office. The Social Care Commitment is an agreement about improving workforce quality and providing high quality services in adult social care. Its primary purpose is to ensure public confidence that people who need care and support will always be supported by skilled people who treat them with dignity and respect. The Six Cs are the value base for Leading Change, Adding Value; a framework for nursing, midwifery and care staff. These values were one of the legacies created through 'Compassion in Practice', a three-year NHS and Social Care strategy that concluded in March 2016.

Care workers told us they would report any issues with the quality or safety of people's support to the office, and they were confident office based staff would take action. One care worker said, "If there's anything that's not quite right I'll tell the office straightway and they'll get on it." Another care worker said, "I'm confident to talk to the office. [Registered manager] runs a tight ship. We all know what's going on."

The registered manager delegated tasks, such as quality assurance interviews, reviews of records of care and staff supervisions across the office based team. The registered manager checked these tasks had been completed and completed monthly audits to ensure the quality and safety of the service. The registered manager monitored the electronic call monitoring records for missed or failed visits of care and produced monthly summaries of issues. They escalated issues where people repeatedly refused access or were unavailable to receive care appropriately with funding authorities.

The registered manager completed monthly audits of referrals received and packages of care that were started. This captured the reasons why referrals had not led to packages being taken on and meant the registered manager had clear information to feedback to commissioning authorities about the challenges they faced in delivering a service. For example, the registered manager had identified multiple referrals had not progressed due to a failure of the commissioning authority to provide the information needed to complete the assessment. These audits also considered the staffing capacity of the service, and meant they were able to inform commissioners in advance when they knew capacity would be limited. For example, the provider had known they would be unable to take on new packages of care due to a large number of staff observing a religious festival and taking annual leave.

The registered manager and other office based staff completed checks on the quality of the care plans and records of care. These were noted in the individual records and where appropriate, in staff files. However, the registered manager did not maintain a record of the issues identified and addressed. This meant there was no system in place to support the identification of themes in the issues found across care plans and records of care. Likewise, although the registered manager produced an action plan in response to the inspection feedback, there was not a branch level development or improvement plan in place. The

registered manager told us there was a provider level strategic plan for the company but nothing was in place at a branch level.

Throughout the inspection the registered manager and office based staff team responded positively to feedback. For example, where we identified a lack of detail in care plans and risk assessments they took action to improve the level of detail. Where some practices, such as description of legally appointed decision makers, and medicines management, were not in line with best practice guidance, the registered manager immediately referred to the guidance in place. However, the systems to identify issues and apply best practice were not yet embedded in the service.

We recommend the provider seeks and follows best practice guidance from a reputable source about ensuring effective quality assurance systems are in place and best practice resources are utilised.

Throughout the inspection we saw staff visited the office and interacted easily and comfortably with managers; there was a cheerful and supportive atmosphere between the staff. We saw care workers, supervisors and coordinators were all comfortable and confident to ask questions and seek feedback from the registered manager. Staff confirmed there were monthly meetings for the entire staff team. Records showed staff discussed aspects of their roles and values such as personalisation and dignity during these meetings as well as task and administrative aspects of their roles such as IT systems and timekeeping. As not all staff were able to attend meetings in person, records were shared with staff as they visited the office.

The provider operated an annual staff survey to seek more detailed feedback. The branch had only been operational for a year at the point of inspection and the results of the survey had not yet been analysed.

People and their relatives told us they were asked for their opinion on the service. There were monthly telephone surveys and annual questionnaires which were used to seek people's views on their experiences and suggestions for improvements. These were not yet incorporated into an overall development plan for the service.

The provider also sought feedback from professionals who worked with the service. We saw feedback from social workers and other allied professionals who were positive about the approach of the service. One comment detailed the care workers had worked well with other healthcare professionals and recognised the coordination and escalation of issues by the provider.

The registered manager attended the local provider's network hosted by the local authority. This helped them to stay up to date with developments and issues in the local area. The provider had recently undertaken training with a local hospital to ensure key staff were up to date in practices relating to pressure area care. We saw the registered manager had established effective working relationships with other organisations in the borough. They were working with a local learning disability organisation to ensure the people they supported were able to access services. They also supported several people who received joint packages of care with other personal care providers. The feedback from people and their social workers showed these packages were working well as the providers were working in partnership with each other.