County Care Berkshire Limited

County Care (Windsor)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

County Care (Windsor) provides personal care to children and adults. The services provides care within a large part of Berkshire, including Maidenhead, Windsor, Ascot, Slough, Bracknell and villages near these towns. The service has operated for a period of five years. County Care (Windsor) is provided by a limited company with a registered nurse and social care practitioner as directors. The office is based and operated from a busy commercial hub in Windsor.

Staff provided care to people within their own homes. Services provided ranged from assistance in the morning (including helping people get out of bed, wash, get dressed and have breakfast) shopping, preparation of food, medication prompting and assistance with evening care routines. People also received end of life care.

At the time of the inspection, there was a registered manager. 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 service has not previously been inspected since registration at the current location. Therefore, this is the first inspection of the location under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and rating required by the Care Act 2014. Previous inspections at the prior office location were completed by us, but are now archived. You can view all previous inspections of this service on our website.

At the time of the inspection, 43 people used the service and there were 49 staff. People received calls in their house at set times throughout the day. The service also operated 24 hours a day, seven days a week and people, relatives, staff and healthcare professionals could telephone the service at any time to receive support. After hours, calls were diverted to the on-call supervisor or manager's mobile telephone.

People were protected against abuse or neglect. People's and relatives' opinions of safe care were overall positive. We made a recommendation about recruitment checks and personnel files. There were sufficient staff to meet people's needs and the service appropriately determined correct staff deployment. Feedback from people and relatives indicated calls were made on time without delays. People's medicines were administered, stored and disposed of appropriately. The service needed to ensure that medicines administered were always signed for.

We found staff received induction, most training, supervisions and most performance appraisals. We made a recommendation to the provider about appropriate oversight of all support provided to staff. Consent was gained before care for a person was commenced and people's right to refuse care was respected by care workers.

Staff were kind and caring. People's comments showed they were satisfied with the care they received. We

determined care workers respected people's privacy and dignity, and ensured people remained as independent as possible. People had regular opportunities to provide feedback to the service and also have a say in their care package.

The service was responsive to people's needs. People had the ability to share their compliments, concerns and complaints in an open and transparent manner. Where feedback was provided by people or relatives, management would undertake necessary investigations, make changes to their care package and report back to the person. People's care plans were person-centred.

There was positive engagement by the service with community health professionals and commissioners. There was a good workplace culture, and staff expressed their satisfaction of working for County Care (Windsor). Appropriate audits were completed, recorded and reviewed to drive improvements in care.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse or neglect.

People's risks were adequately assessed and mitigated risks.

The service deployed satisfactory numbers of staff.

The service managed people's medicines safely.

Is the service effective?

Good

The service was effective.

Staff had appropriate support with training, supervisions and performance appraisals.

People's consent for care was obtained in accordance with the Mental Capacity Act 2005.

People were supported to maintain a healthy balanced diet.

People were supported to have access to healthcare services and receive ongoing support from community professionals.

Is the service caring?

Good

The service was caring.

People were treated with kindness and compassion.

People had choice, independence and control of their personal care.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

The service listened to people's wishes and preferences.

People's care plans were person-centred.

Staff had good knowledge of the people they cared for.

There was a satisfactory complaints process and people knew the procedures for raising any concerns.

Is the service well-led?

Good

The service was well-led.

There was a positive workplace culture.

The conditions of registration were met by the service.

Audits were completed to monitor the safety and quality of people's care.

County Care (Windsor)

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 was undertaken by one adult social care inspector, took place on 15 December 2016 and was announced. The provider was given 48 hours' notice of our visit, because the location provided personal care in the community and we needed to be sure that staff and managers would be present in the office.

Leading up to the inspection, we sent 74 surveys out to people who used the service, relatives, staff and community professionals. We received seven replies. An Expert by Experience also conducted telephone surveys with people and relatives before the inspection. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience was able to speak with four people who used the service and one relative. We e-mailed all of the location's care workers during the inspection process and asked for their feedback. We received two replies. In addition, we received written feedback from two community health professionals who worked with the service.

For this inspection 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. We reviewed information we already held about the service. This included statutory notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public leading up to the inspection.

At the inspection, we spoke with the registered manager and nominated individual. We also spoke with the location's compliance and care coordinators. We did not visit people's homes as part of this inspection.

We looked at six sets of records related to people's individual care needs. These included risk assessments, support plans, medicines administration records (MARs) and daily care worker notes. We also looked at five

staff personnel files and records associated with the management of the service, including quality audits.

Good

Is the service safe?

Our findings

Results from our pre-inspection survey and telephone interviews demonstrated that people felt safe with the care provided by County Care (Windsor). A relative told us, "Yes. They are so kind. They know what they are doing. We changed from the one we had about two years, so they are trying their best." A person who used the service told us, "Oh yes I do. Very good. I used to have panic attacks, but they are very good at calming me down by talking to me." Another person said, "I don't feel uncomfortable." One person stated, "Yes, very happy with them. They are on time, seem very efficient and they do the job I ask them to do." One person gave extensive feedback about how they felt the service provided safe care. They told us, "They are amazing with me. I had physio at home and two carers came in their own time to see what the physio was doing. They make sure I do the exercises the physio was doing. I have the same three people for continuity of care. They are so patient. They will wait awhile whilst I practice doing my buttons up. I don't feel rushed. They want me to do more and I am doing better. They come up with ideas of their own and implement them."

People were protected because systems were in place to prevent abuse and neglect. The provider had appropriate policies for safeguarding and staff whistleblowing, and these were up-to-date. The service's policies were in accordance with the Care Act 2014. The service had access to a copy of the Berkshire safeguarding adults procedures, which contained the necessary information about dealing with and reporting abuse or neglect for the region. The registered manager and nominated individual were clear about their part in managing safeguarding concerns. This showed the service was aware of procedures to protect people. Care worker inductions and training included safeguarding theory and practice. Staff training about safeguarding vulnerable adults was robust, as there was the requirement to attend a half day course and annual updates to refresh their knowledge. We found increased visible information about who to contact for safeguarding referrals in the office was needed. During the day of the inspection, the registered manager organised additional signage to be placed around the office. Staff were then able to have easier access to the appropriate contacts.

The service assessed and managed people's risks of personal care. We found care documents contained satisfactory risk assessments and management plans. We looked at care records for people who used the service. In the risk assessments and care plans we examined, we saw a comprehensive range of documents. Examples of risks recorded included environmental hazards in people's homes, moving and handling, falls, medicines administration and nutrition and hydration. People could call the service after hours for help if needed. Where necessary, the service's management were called or medical help obtained.

The service ensured that people were protected from risks associated with their care and documented when harm occurred. Staff documented incidents or accidents to people when they occurred. We found there were accident forms completed by staff since our last inspection. We saw these reports were reviewed by the registered manager. There was good evidence of how the incident occurred and what happened afterwards to deal with the situation. Where risks to people were identified in the accident report, necessary changes were made to their care.

Although people's individual risks were assessed and managed, the service did not have a business continuity plan in place at the time of the inspection. A business continuity plan is an essential part of any organisation's risk planning. It sets out how the business will operate following severe events and how it expects to return to 'business as usual' in the quickest possible time afterwards. The registered manager and nominated individual acknowledged this once we pointed this out at the inspection. Immediate action was taken by the management to develop and implement a business continuity plan.

Sufficient staff were deployed to meet people's needs. We were told the minimum planned care call lasted 45 minutes. This was to ensure that care could be provided at an appropriate pace for people. We found no evidence that calls were shortened by staff once the personal care element was completed. Instead, care workers used this time to complete other tasks for people or socialise with them. Staffing deployment was also based on people's choice and the person's care needs. For example, where hoists were needed to move people, a mandatory minimum number of two care workers were planned. The service had implemented live computer-based monitoring of care calls in 2016. We examined how this operated and how calls that ran late were flagged up to the office coordinators. When calls were delayed, care coordinators contacted people to advise them of this. We found no evidence of missed calls. However, the service did not have a suitable method in place to monitor missed calls. We pointed this out to the management of the service at the inspection. They agreed with our finding and reassured us a method would be used to track and record any missed calls.

People were not always protected because the service had failed to follow robust recruitment procedures. There were limited instances where staff documents or checks were missing. We looked at five personnel files of care workers. We found personnel files contained most of the necessary information required by the applicable regulation and schedule. The service recorded staff's legal right to work in the UK. We saw evidence of all staff criminal history checks via the Disclosure and Barring Service (DBS), proof of identification and checks of previous conduct in most other roles. The service did not always ensure that appropriate checks of applicants' prior work conduct were in place. Where necessary, the service had not obtained additional references to ensure that applicants were suitable for the role of care worker. Full employment histories of applicants were not always completely documented. We pointed this out to the management of the service who were receptive to our findings.

We recommend that the service implements increased robust personnel file processes, in line with the requirements set by the applicable regulation and schedule.

People's medicines were safely managed. We were told that in people's homes, medicines were often pre-packed into blister packs by the dispensing pharmacy. Some people took medicines without assistance. Staff supported people to take medicines only if they required assistance or were unable themselves. Staff completed training in medicines safety. Staff training included both theory and practical demonstrations of medicines administration. New care workers were shadowed during induction to check their competency with the safe administration of medicines. We looked at three people's medicines administration records (MARs). We saw that on limited number of occasions, the care workers administered medicines but failed to sign. However, we found this was always followed up and signatures were obtained. The registered manager and nominated individual were aware and explained that they implementing a changed system for MAR charts and enhancing checks. We saw the evidence this process was underway. The changes in progress would strengthen the safety of people's medicines administration. We saw some people were prescribed 'as required' medicines, like paracetamol for pain. We advised the management that protocols for all 'as required' medicines were considered best practice. They agreed to complete these for all people who had 'as required' medicines on their MAR charts.

Good

Is the service effective?

Our findings

We saw the service recorded staff training, supervision and appraisals in a database which showed the due date for it to be completed and the date it was attended. The database also flagged up to management when training, supervision or checks were overdue. As the system recorded individual staff training and did not provide a service-wide view or percentage of completed staff training, we were unable to determine at the inspection that appropriate staff support was offered. The provider was also not able to readily deduce that overall staff support was appropriate. We asked the provider to send us staff support data following our visit, and this was promptly received for us to analyse. For the purpose of checking the appropriate regulation about staff support, we excluded staff that had recently commenced at the service from our check.

The evidence we received showed that staff could complete training in a large range of mandatory or legislative topics, as well as some additional topics which provided advanced knowledge or care practice. For example, there was training available in moving and handling, basic life support, safeguarding adults at risk and health and safety. We saw there was a good completion rate by staff in those subjects and that completed training for most staff was within the last calendar year. A small number of staff had completed training in the additional topics like epilepsy management, management of people's skin integrity and feeding people using artificial methods (PEG feeds).

We found training overall at the service was appropriate. A small number of topics considered necessary for care workers had low completion rates by care workers. Example topics for low rates of attendance included food hygiene, infection prevention and control, record keeping and the Mental Capacity Act 2005.There was a lack of oversight in what percentage of staff had successfully completed or repeated the topics necessary to provide personal care to people.

We recommend that the service ensures robust oversight of all staff training, supervisions and performance appraisals.

Staff could participate in appropriate supervision or support sessions with senior staff or managers. There was a system of field-based checks, office based supervision sessions and the ability to complete an annual performance appraisal. We found that the amount of field-based and office based supervisions with staff were satisfactory. The majority of staff had completed performance appraisals.

We found appropriate subjects related to being a care worker were covered during induction. We found topics included safeguarding children and adults, safe moving and handling, infection control and understanding mental capacity. The service used industry-wide training methods for adult social care staff, such as Skills for Care's 'Care Certificate'. New care workers were required to undertake the required 'Care Certificate' to ensure they were able to carry out their roles and responsibilities. New staff completed office-based training for three days, shadow shifts with an experienced care worker for three or four days and then a competency check. The new worker could commence care calls on their own if found competent. Some staff required additional coaching or support during induction, and this was provided as needed. Field

supervisions of newer staff happened within three months, and probation of employment was completed at six months.

Four people and one relative we spoke with told us they felt that staff were trained appropriately to help with personal care needs. The relative said, "Yes. He can do most things himself, but they are there in case he falls. They are very well trained; it's sufficient for what we need." A person we spoke with told us, "Yes. They have shadowing which is learning. I can tell them when they are doing something right." When asked, another person said, "Yes, one or two are particularly good." Another person told us, "Oh yes. I have no knowledge in this field but they have given me the benefit of their experience. Very capable people." From our survey prior to the inspection, all four people who provided a response agreed with the statement 'My care and support workers have the skills and knowledge to give me the care and support.'

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 the time of the inspection, the service worked in line the requirements set by the MCA and the associated Codes of Practice. We found consent was always gained for people's care. We saw consent was obtained from people who had satisfactory mental capacity to make the decision themselves at the time. There was a risk however, that the service might ask relatives or 'next of kin' for agreement and signatures on consent forms. Care coordinators and other office-based staff were aware of individuals who had deputies or attorneys appointed. The service was able to demonstrate that they attempted to obtain copies of legal documents to prove third parties were able to legally consent for people. This was an area the service had identified themselves as an area for improvement. Where there was no one who could legally consent for a person, the service did have a best interest decision-making process in place. The registered manager and nominated individual understood the MCA and consent processes. Appropriate forms were used to document all consent, and we viewed completed examples from people's files.

Some people who used the service received support with food shopping, eating and drinking and the preparation of their meals. Where necessary, the person was encouraged to be as independent as possible in heating, cooking and eating their meals. People's records contained assessment forms about eating and drinking. Where necessary, meal logs recorded what people had to eat and drink. We viewed an example of the meal logs and found these were appropriate. Staff called health professionals if people with health conditions did not consume sufficient food. This ensured the risk of malnutrition over time was mitigated for the person. We saw people's preferences for meals were recorded. Daily care notes showed when people were assisted with eating and drinking.

We saw people were supported by the service to attend all necessary medical and healthcare appointments away from their own homes. Examples of good support to people related to healthcare included assistance with GP visits, dentists and opticians. The service had also arranged GP home visits and visits by district nurses. The nominated individual was a registered nurse and could provide advanced care advice to care workers who needed additional support with people's care.

Good

Is the service caring?

Our findings

People and a relative we spoke with felt that care received from staff and the office was kind. When we asked if staff were caring, the relative said, "They are friendly to him." A person we asked told us, "Yes, I cannot complain. If I am feeling a bit down, they give me a cuddle. There is one who when she leaves [expresses her enjoyment of working with me]." Another person stated, "Yes. It was an effort to take me to the [community] hall. They stayed with me, brought me home and made me a cup of tea. They are prepared to take me to appointments." Another person said, "They came to visit me in hospital and met me to see me use this piece of equipment, which was new, to find out how I moved about. I came out of hospital and she knew how to move me." In our pre-inspection survey, all five people recorded they were content with the professional relationships they shared with staff.

People felt involved and engaged in their care. Their feedback to us demonstrated that staff knew them and allowed them to have a say in their care. The relative told us, "Yes they know his needs he lies in bed all day." When we asked a person if staff included them in the care process, they said, "Yes, most of them do." One person said they were particular in their care package about their diet and social life. They told us this was included and respected in their care. The person said, "I like freshly cooked food and I belong to the National Association of Fine Arts. They have collected and taken me to these events." Another person told us about their ability to make decisions about care. They commented, "They certainly do. I lack confidence. They know me and know how to build my confidence. They say what you have done good [and] what could you do to make it better. [They are] very quick to sum people up. They know their clients." The relative and three people we spoke with told us they knew about their care plans, were involved in creating them and reviewing content. The registered manager confirmed that care plans were reviewed at least six monthly, but more often if people's needs changed.

We did not visit people's homes as part of this inspection. However, we were told that when personal care was provided, care workers ensured people's privacy and closed bedroom doors and curtains in people's homes. People's comments confirmed this. We found some staff had received training in privacy and dignity and this was embedded into the care they delivered to people. The registered manager explained how people's privacy and dignity was respected during care calls. This included announcing their arrival to the person's house and seeking permission to enter, closing doors and curtains and covering people during washing or dressing.

Confidentiality in all formats such as paper-based and computer-based documents was maintained. Staff had commenced using a system on mobile phones to record their arrival to and departure from people's visits. We saw the mobile phone application was via a login and password specific to each staff member. The company that made the mobile phone application proved that confidential information sent to and from the phone was securely protected via encryption. People's confidential personal information was regularly removed from the care file in their apartment and placed into secure storage at the service's office. The service's storage areas and offices were locked when staff were not present.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO).

The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We saw evidence of the ICO registration by checking the regulator's website.

The management team explained the service provided some end of life care at the time of the inspection. They expressed the desire to increase this ability to people who needed it. The service had commenced consultation with a local hospice to plan a seamless transition for people between both services. Preliminary discussions had occurred, but we heard further planning was underway to build on this service idea.

Good

Is the service responsive?

Our findings

People who used the service confirmed to us they had expressed their personal needs and preferences before care commenced and throughout continuation of their care package. We looked at six people's care documentation to check whether care was responsive. We found that people were free to choose what aspects of care they needed assistance with, and the service encouraged people to remain as independent as possible. The registered manager explained that at first visits, staff asked for information to ensure the person received a care package dedicated to them. When we looked at the care documentation, we found a profile pages. The document listed important information about the person. This included their social and family history, any communication difficulties and people's preferences or wishes.

We found care was person-centred. Staff had the necessary knowledge of people they cared for. The remaining content of care files we saw included appropriate care planning forms which were completed dependant on each person's unique needs. In the examples we reviewed, we could see people's likes, dislikes and preferences were recorded for each domain of their care package. The service considered each person and their care package was different, and the care files we reviewed fully demonstrated this. Daily notes by staff were recorded in a professional context with satisfactory details of the care provided. We spoke with a relative and people about whether the service was responsive. They felt the service provided person-centred care. The relative told us, "[Staff] came around and looked at what needs to change." A person we spoke with regarding their type of care said, "We were in consultation with them and my family." Another person we spoke with regarding their preferences said, "Yes, any carer who is new has to read it (the care plan) before they do anything."

People were offered gender-specific care workers if they have a preference. This respected people's rights to choice in their care. A relative we spoke with said, "[The person] doesn't mind, but they don't have any male carers." A person we spoke with told us, "Oh yes, they asked me if I wanted a male carer I said 'no'. I didn't want a strange man. They made a mistake and sent one. I phoned the office; they apologised and said it wouldn't happen again." This person went on to tell us after this they always received a female carer and this was in line with their preference. Another person we spoke with said, "Yes, offered a male but I prefer a female."

People told us they knew how to make a complaint and would not hesitate to raise concerns. Three people we spoke with told us they had previously raised concerns with the service. One person said they expressed concerns about the way a particular care worker treated them. The person told us the service was receptive to their feedback, and agreed to an ongoing replacement care worker. Another person told us they had difficulty in communicating with a team member in the office. The person told us they spoke with the registered manager and the issue was immediately resolved. The person said, "They are very nice. Just not always good at communicating. We are alright now." We were satisfied that people felt confident about making complaints.

The service listened to and learnt from people's experiences, concerns and complaints. The service user guide explained to people how they could provide feedback to the service. The complaints policy and

procedure contained the information for various staff members regarding their role in acknowledging and managing complaints. We pointed out to the registered manager some additional information could be added to improve the information for people about making a complaint. They were receptive of our advice and agreed to insert additional contacts details so that people knew who to contact to raise concerns.

We saw detailed records of concerns and formal complaints for 2016. These were centrally stored and information pertaining to each case was kept with the concern for review in the future. The management team had a clear strategy for concerns and formal complaints, and how these were differentiated. Office-based staff were required to record and resolve peoples' or relatives' concerns within 48 hours of contact. If they could not solve the issue, the matter was escalated to a management team member for review. The service was required to acknowledge formal complaints within seven days after receipt and submit an outcome to the person as soon as possible. Investigations were completed by the management and these were appropriately documented. Set response timeframes of 14 days and 28 days for correspondence with people were in place, depending on the nature of the complaint. There was the ability to escalate complaints to the nominated individual of the provider if people felt their complaint was not handled well by the registered manager.

Good

Is the service well-led?

Our findings

The service worked well with partner agencies. A community health professional provided positive feedback about the service. They replied, "I have commissioned County Care to provide packages of care for a wide range of patients. They have been first rate at gaining patient knowledge, going above and beyond to provide a personalised service. They have worked really hard at successfully maintaining packages of care for end of life patients and those with chronic conditions ensuring families and patients are kept well-informed and provided with continuity and consistency of care. County Care is managed well by ([the registered manager and nominated individual)]. To date I have not had to manage any complaints about their service provision. I have found their responses to requests for care to be rapid and thorough. Their attention to detail is exemplary."

Other health professionals who we communicated with agreed the service was well-led. One wrote, "This care agency is very professional and the managers expect and command a high standard of care to be delivered to all clients. I would happily use County Care for a member of my own family should the need arise and would feel confident that they would receive an excellent standard of care." Another health professional told us, "I have been very impressed with the management and leadership of this agency. I have recently used them to take over two complex care packages and this was done with upmost professionalism and attention to detail, involving all with the care provision, appropriate training and supervision along with the clients themselves."

We found a positive workplace environment was present at County Care (Windsor). In our survey, six staff who responded told us they were satisfied with the care the service provided and management. One staff member stated, "I am happy to work with County Care Berkshire . I was trained to do my job well and all the staff are prompt and efficient every time that I need [something]." Another staff member wrote, "One of the best care agencies I have worked for." We observed the small office team worked well together and were pleasant with people during telephone calls. Due to a wide geographical area of care provided to people, staff were divided into teams and their work was hub-centred. This reduced the chance staff may not know particular locations or have to travel too far for their calls. We saw staff meetings took place regularly and the management were involved in the everyday running of the service.

The provider complied with the requirements of their registration with us. There was a registered manager in post at the time of the inspection. We found that the registered manager was supported by two care or compliance coordinators and the nominated individual. We found the management team honest, approachable and professional. The service was required to have a statement of purpose. A statement of purpose documents key information such as the aims and objectives of the service, contact details, information about the registered manager and provider and the legal status of the service. We found the statement of purpose for the service was appropriate. The registered manager sent us an update of the statement of purpose after the inspection.

Due to the type of service provided, there were a limited amount of times that the provider needed to legally notify us of certain events in the service. When we spoke with the registered manager they were able to

explain most of the circumstances under which they would send notifications to us. We checked our records for notifications the service had submitted to us. We found the service had submitted some notifications. We found the registered manager did not fully understand in what context to send allegation of abuse or neglect notifications to us. We examined examples of incidents with the registered manager at the inspection. We also spoke with the local authority to check what cases were referred to them in 2016. Although people were safeguarded by the service, we found two instances where it was necessary to send us notifications in November 2016. The registered manager did not submit them at the time. Once pointed out at the inspection, the registered manager rectified this immediately by sending us the applicable notification forms . We are confident the registered manager understands their legal duties in submitting notifications when required.

There were a good number of quality checks undertaken by the management to ensure good care. Care workers had random visits ('spot checks') by managers during care delivery, to ensure people's care was provided safely and effectively. We found the service checked daily notes from care workers when they returned to the office. Checks of medicines administration records (MARs) were conducted monthly. The registered manager told us the service was changing this to weekly from January 2017. This was to ensure even more managerial oversight of medicines safety. Personnel file audits were last completed in August 2016 and found some areas where improvements were necessary. These were not all completed at the time we completed the inspection. The nominated individual conducted quarterly self-checks of the entire service. We viewed the results up to August 2016. We saw these looked at service issues such as business premises and staff, audits, 'service user' records, complaints and compliments and other documents. The management team identified areas of the service that required improvements and what actions they would take. We advised the registered manager a single service improvement plan to record all risks and planned actions could be implemented. They agreed with our comment and advised us they would discuss this further at their next board meeting.

Providers are required to comply with the duty of candour statutory requirement. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The regulation applies to 'registered persons' when they are carrying on a regulated activity. The registered manager was familiar with the requirements of the duty of candour and was able to clearly explain their legal obligations in the duty of candour process. The service did not yet have an occasion where the duty of candour requirements needed to be utilised. At the time of the inspection, the service had a satisfactory duty of candour policy.