I Care Service Norfolk Ltd

I Care Service

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

This inspection was announced and took place on 5, 6 and 14 December 2018. We had not inspected I Care Service since a change in their registration (legal entity) in August 2017. Whilst they had retained the structure and significant personnel of the previous company, newly registered services are assessed to check they are safe, effective, caring, responsive and well-led. As such, they had not yet received a CQC rating.

I Care Service is a service based in Dereham, which provides personal care to people in their own home. At the time of our inspection the service was providing care to 79 people living within an approximate 10-mile radius of Dereham. The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'.

A manager was in post, who re-registered with the CQC at the same time as the service was re-registered in August 2017. A registered manager is a person who has registered with the CQC 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.

Improvements were required to care plan records. We found the assessments of peoples' needs, choices and risks varied in quality. Care plans represent people's needs, preferences and life stories to enable staff to fully understand people's needs and wishes. There was usually a good overview of the situation and support required. However, we found limited details in care plan records and individual risks had often not been assessed and mitigated for in people's care plans.

People told us they felt safe receiving the care and support provided by the service. Staff understood and knew the signs of potential abuse and knew what to do if they needed to raise a safeguarding concern.

Robust recruitment and selection procedures were in place and appropriate checks had been made before care staff began working at the service. People were receiving calls at their preferred time but feedback regarding the consistency of care staff was mixed. Whilst the service acknowledged that they had had recruitment and retention difficulties previously, the evidence indicated that there were now enough staff to provide care and protect people's health, safety and welfare in a consistent and reliable way. People using the service noted that this had led to more consistency of staff provided recently, promoting positive relationship building and more person-centred care. The registered manager was working creatively to recruit and retain staff.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines administration was audited weekly by a designated staff member and medicines were managed safely. Staff were aware of appropriate infection control measures.

When incidents had occurred, the registered manager was able to explain analysis and demonstrate improvements and changes in procedures had occurred where appropriate. However, there was not a structured recording or systematic analysis process to ensure 'lessons were learnt' and incorporated into practice

People using the service felt that staff mostly had the skills required to provide the service safely and effectively. Staff had received appropriate induction training, tailored to the level of experience and knowledge of each new starter with shadowing and competency checks completed before staff worked independently. Staff had ongoing supervision and competency checks regularly.

Training records were not clear that all staff were receiving training in all core subjects and showed that not all staff were receiving regular refresher training in core subjects. Staff however demonstrated good knowledge and understanding of the skills needed to provide care, including safeguarding adults at risk.

People reported they were supported to choose their own food and drink and maintain a balanced diet where this was required. Some feedback from people indicated that not all staff had sufficient knowledge to cook simple food.

Health care needs were met well, with referrals and liaison with healthcare services made when necessary and escorts offered to medical appointments as required. The service kept a separate record of communications with external professionals to monitor and manage this support.

The management team and staff had an understanding of the Mental Capacity Act 2005 and consent to care and treatment. The service was aware of enabling choice and promoting decision-making by people using the service whenever possible. They consulted appropriate representatives where mental capacity to make a specific decision was lacking.

Staff treated people with kindness, compassion and respect. The service had a good understanding of people's needs and promoted choice and independence. Staff usually recognised people's right to privacy and promoted their dignity, although sometimes, particularly when demonstrating care to new staff, staff were not always ensuring dignity and privacy were respected.
We found the service took a personalised response to care provision and sought regular feedback from people using the service.

There was a complaints policy and information regarding the complaints procedure was easily available. All listed complaints had been responded to by the manager in person and via letter to the complainant,

The service provides appropriate end of life care and support, working with allied professionals as required.

Staff felt supported and valued by the service's management. Staff were encouraged to provide feedback and report concerns to improve the service and the management gave staff clear leadership. The service had developed an open and positive culture, which focused on improving the experience for people and staff. The role of senior care staff had been introduced, with the aim of improving consistency in the delivery of care, support for newly employed staff and an additional link between the office and people being supported in their own homes.

We found the management of incidents and complaints required improvement. Management had responded appropriately to people using the service. However, there was not a systematic procedure and recording system to support this process or incorporate lessons learnt. We found that the service did not

always notify the appropriate authorities of safeguarding incidents and their outcomes as required and was not sufficiently aware of this duty. The management did however redress this concern during the inspection, through implementation of a clearer incident process and recording system.

We found that quality assurance practices required improvement. Audits were not always systematically managed or recorded to ensure accurate records, analyse practice or drive improvements.

The registered manager attended local forums and sort external feedback to promote learning and improvements. We found the registered manager approachable, open and enthusiastic about providing a high standard of person-centred care to people.

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.

The service did not sufficiently assess and mitigate for risks to people using the service.

The service had improved and implemented adequate practices and procedures for medicines administration.

The service had appropriate infection control practices.

The recruitment practice was good, ensuring the service employed staff who were safe and appropriate to work in a caring profession. The service had sufficient staff to provide people with the care they needed.

The service knew how to reduce the risk of people experiencing harm and abuse and took actions to safeguard people when required.

The provider did not always notify the appropriate authorities when a safeguarding incident occurred which they are required to do to ensure appropriate oversight and reflection of practice.

Is the service effective?

Good

The service was effective.

The staff had received training on how to provide people with care and their competency to do this effectively and safely was reviewed.

The staff knew how to apply the principles of the Mental Capacity Act 2005, seeking consent as appropriate and acted in people's best interests where they couldn't consent to their own care.

Where it was part of the care package, the staff supported people to eat and drink sufficient amounts to meet their needs. They also supported people with their healthcare needs.

Is the service caring?

Good

The service was caring.

The staff were kind and caring, supported people to express their views and choices. They usually treated people with dignity and respect.

Is the service responsive?

Good

The service was responsive.

There was a personalised summary of people's situation and the tasks required which was reviewed on a 3-monthly basis.

People's preferences and their desired outcomes were being met.

People knew how to complain. When a complaint had been received it had been investigated and responded to by the provider.

The service was responsive to people's individual changing needs and provided end of life care when required.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We were not assured that there were sufficient systems in place to monitor the quality and safety of care provided. There was not a comprehensive and systematic approach to quality control audits.

Management had not identified the quality of care plan and risk assessment records were not usually sufficiently person centred, holistic or detailed enough to promote high quality care.

Training records had not been sufficiently audited to ensure staff had completed all training required.

Whilst the management had reflected and adapted practice following some incidents, there was not a systematic process for analysing and learning from incidents.

The registered manager was not aware of all their regulatory responsibilities in relation to notifying appropriate authorities of incidents and had not being do so.

The registered manager operated in an open and responsive way. Management were accessible and actively encouraged feedback from both people using the service and staff.

The staff understood their individual roles and responsibilities and were given appropriate leadership, support and guidance on working practices.

Management had a comprehensive service development plan and were engaged with external forums to learn and improve working practices.

I Care Service

Detailed findings

Background to this inspection

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

This inspection was a comprehensive inspection; it took place on 5, 6 and 14 December and was announced. The provider was given 48 hours' notice because the service provides people with care in their own homes and we needed to be sure that people would be willing and available to speak with us and to ensure that the registered manager would be in. The inspection was carried out by two inspectors 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. Their expertise was in caring for older people who use regulated services including people living with dementia.

Before the inspection we reviewed the Provider Information Return (PIR). 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. We also reviewed other information that we held about the service. Providers are required to notify the Care Quality Commission about events and incidents that occur including injuries to people receiving care and safeguarding matters. We reviewed the notifications the provider had sent us. We also contacted the local authority quality assurance team for their views.

During the inspection, the expert by experience talked with 6 people using the service and 4 relatives by telephone. An inspector also visited 2 people using the service. In the office, the inspectors met the registered manager and 8 members of staff. We reviewed 7 case files of people using the service, daily care logs and medicines administration records. We looked at 6 staff recruitment files along with the staff induction, competency and training records. We reviewed incident and safeguarding records as well as complaints and compliments received. We reviewed a range of quality assurance tools, minutes of staff meetings, the annual survey of people using the service with accompanying analysis and the providers' service development plan.

Requires Improvement

Is the service safe?

Our findings

The initial needs and risk assessments in all seven files reviewed were not sufficiently holistic and were limited in detail. Any risk assessments completed were usually not dated to aid checking ongoing validity. For example, people with limited mobility did not consistently have moving and handling risk assessments or pressure sore risk assessments. Two people using the service were known to have experienced significant continence issues due to medical conditions which had resulted in medical emergencies. However, there were not clear risk assessments or appropriate recording systems in place (such as bladder and bowel output charts or infection control risk assessments) to aid monitoring and management of these ongoing risks or inform integrated working with healthcare professionals. It is possible greater monitoring may have supported earlier medical intervention and averted medical crises. We found there were often generic risk assessments (for example for fire safety and infection control) that were pre-populated and had not been personalised to the individual situations of the people using the service and so were not appropriately mitigating for potential risks. The provider agreed that their assessment records required improvement.

The provider currently administers medicines to 15 people using the service and we found the administration was now adequate. Feedback from people receiving support with medicines administration was positive, one person saying, "They wear gloves when doing my medication. They pop the tablets into a pot for me and make sure I take them with a drink."

Following an internal review of significant concerns and repeated incidents regarding medicines administration a year ago, a new post of 'medicines officer' was created. The medicines officer was responsible for ordering, collecting and monitoring of all medicines administered. This officer completed weekly audits of the medicines in each person's home and the associated medicines administration records. Practice guidelines for staff had also been revised, with implementation of a medicines administration records, separate to care plans, which staff are encouraged to use away from the people using the service to avoid distractions.

Where staff are administering topical treatments such as pain patches or creams the service usually provided guidance to staff on how and where to apply safely. However, we found in one case this was not provided for prescribed creams, which the service agreed to rectify immediately. Where people had medicines prescribed as PRN (as and when required), the provider showed us that protocols were in place to guide staff on when to give people these medicines.

Whilst assessments listed significant health conditions and medicines prescribed there was no explanation as to the potential impact of these on the delivery of the care plan by staff which could promote safer care. The provider agreed they would rectify this omission.

The audits showed that medicines administration errors were now rare (three in the previous six months). The registered manager had not notified the local authority safeguard team and Care Quality Commission of the medicines administration errors as required by regulations, but advised that they will ensure this is done in future.

The registered manager explained how they reviewed all incidents to look for themes and lessons to be learnt, and this was demonstrated in the changes to the medicines administration system as noted above, however there was no specific record of these management reviews.

We checked staff recruitment files and found that the provider had implemented a thorough recruitment process. All staff had been subject to an appropriate Disclosure and Barring Services (DBS) check as is required. This is a check to ascertain whether the staff member has any criminal convictions or has been barred from working within the care sector. The provider had checked the identification of the staff, gained a minimum of two references and a full employment and education record. This is required so the provider can ensure that potential staff are of good character and have genuine reasons for gaps within their employment history.

We noted the provider asked whether the staff had any health conditions that might affect their ability to work; however, where one staff member had indicated a potential concern, the provider had not followed this up with an appropriate risk assessment. The provider agreed they would rectify this omission.

All the people we spoke with who used this service said they felt safe with the staff from I Care Service. One relative said, "They are very good, they make sure [my relative] is sitting safely on a chair in the bathroom and that they are safe before they leave."

The provider acknowledged that they had had a recruitment and retention difficulty in the previous year but told us they now have sufficient staff to cover the care required and usually plan a minimum of 70% of calls with staff familiar to the person using the service. The feedback from people using the service upheld that this was an area that was generally improved, with most now receiving regular staff visiting them.

People who used the service told us staff were usually on time and stayed the length of time agreed. The provider advised there had only been one missed call in the previous year due to an administration error regarding a cancelled call. One person said, "They are normally on time although there have been one or two occasions when they have been late. They do usually let us know." The provider uses an electronic system to monitor the time and length of care calls provided by staff, with the aim of being within 15 minutes of the scheduled times, and audits showed a 93-97% monthly accuracy rate. The provider has recently implemented an online rota system securely accessible to people using the service (or a relative with online access) on a weekly basis, in response to feedback from people using the service wanting to know the rota of staff attending them.

Where staff were sent to a person they were not familiar with, the provider sent a summary of the person's situation and care needs by a secure email which staff were required to access prior to the visit to mitigate against lack of familiarity and ensure safety was maintained. All the staff we spoke with told us there were now enough of them to meet people's needs. They said they were given sufficient time to give people the care they required, although sometimes travel time allowed was insufficient. Sufficient staffing levels were also evidenced by a review of the rotas and daily care logs alongside the fact that office staff, who could be utilised as contingency cover, were not now routinely providing care calls.

All the staff interviewed demonstrated a clear understanding and awareness of the importance of safeguarding people from abuse or harm. They were aware of how to recognise signs of abuse and report any concerns either to the management for action or direct to the local safeguarding team. For example, one staff member gave illustrations of things they looked for, "We look for changes in behaviour or mood, physical signs or things like money or food missing."

Staff were aware of the importance of managing risks, noting for one person using the service who was particularly at risk of falls, that they have supported the person to access appropriate healthcare assessments. Staff commented they "always encourage [the person] to use the toilet whilst I am there to minimise the risk of falls."

Staff were aware of the importance of managing the risk of infection control. We observed good practice during our inspection such as use of protective barriers such as gloves and aprons. The provider had recently introduced training in stoma and catheter care as part of the staff induction to support best practice and minimise risks of cross-contamination. The service was also in the process of implementing oral healthcare care plans where appropriate.

The provider described how they handled safeguarding incidents, demonstrated clear understanding of the presenting situations, sound decision making and appropriate actions taken to mitigate against repetition of incidents. Staff meeting minutes demonstrated lessons were being learnt and disseminated to the whole staff team. However, there was a lack of a clear process and proforma for recording individual incidents, assessing actions required and lessons learnt. This left the provider without clear records of their management of incidents and safeguarding concerns beyond the immediate response to the people involved. The provider also acknowledged that whilst they had referred safeguarding matters to the local authority when required, they had not notified CQC as is required by regulations. The provider agreed that they would immediately rectify these omissions and this was actioned and incorporated into their safeguarding policy during this inspection.

Good

Is the service effective?

Our findings

People using the service all felt the service they received was usually effective and supportive. One person told us, "They all seem to know what to do. We have no issues around that". Most people told us that that staff appeared competent and confident in their role, but some felt that some of the staff could do with additional training or lacked some appropriate life skills. One person told us, "I think they are quite well trained and on the whole treat [person] well." Another said, "Not all of the staff are as well trained as others. The new staff spend some time shadowing more experienced staff for a couple of days. I do think some of them could do with a bit more support, particularly around preparing meals, as some don't know how to cook." One relative commented that sometimes staff expressed a lack of confidence, particularly in the use of moving and handling equipment.

I care provided in-house and external training to support staff to have the skills required for care. They had a part time training manager who leads weekly workshops to support staff with their learning as required. A new induction process had been recently devised which has updated the basic skills and knowledge needed to be completed within the first three weeks. New staff had a minimum of one to three days induction training depending on the level of care work experience and qualifications they had. All staff were expected to work towards completing the Care Certificate within the first three months. This is an industry recognised training programme for staff working within health and social care; many either also had, or were working towards, National Vocational Qualifications (NVQ). Part of their induction involved them shadowing or working with a more experienced member of staff until they were confident they could work independently, this ranged from a few days to several weeks. During this time all staff, regardless of experience, were assessed practically for competency in core skills at least three times by management or senior carers before being able to provide care independently.

The provider advised new staff complete practical assessments for sheath catheters, stomas, medicines management and using of moving and handling equipment including hoists, stand-aids and glide sheets in the office before completing competency assessments in peoples' homes during their shadowing period. The provider operates an exclusion system within the rota system to ensure that staff not trained in a specific task (for example a type of artificial feeding system) or where specific request such as gender of the carer had been made, were managed. We spoke with two staff members who were new to the service. They said their induction had been good and that they had been given sufficient time before being asked to provide care to people independently. They also told us their competency to perform their role had been regularly assessed and feedback given to them as necessary.

All staff had at least three medicines administration competency checks as part of their induction prior to independent administration of medicines and further competency checks every four months thereafter. When administration errors were found, medicines administration incident forms were completed, staff concerned received further training and competency checks prior to returning to independent administration. Two members of staff had also received further training from Norfolk Medicines Support service to ensure best practice was being promoted.

The provider operated a list of ongoing training required by staff and the registered manager advised that training is currently undertaken on a three-year cycle but they were aiming to increase this to annually. Records showed that uptake on the training was not monitored sufficiently and that refresher training had not always been undertaken with sufficient frequency. The registered manager agreed to commence a regular audit the training records, review the industry standards for refresher training and implement an appropriate action plan.

The management do regular spot checks on all staff's competency. Staff reported that they are well supported by the provider and that if they are not confident in a task they are encouraged to seek support from senior carers or management before giving care.

The management completed initial assessments of the care required and outcomes desired. The quality of the content and recording of this assessment was variable and requires improvement to ensure there is adequate details and care plan information for staff to understand the needs and be informed on appropriate delivery. However, there were useful summaries of the care tasks required on each visit which had clearly been devised in conjunction with the person using the service and had the person's signed consent. These summaries were person centred and guided staff providing care to ensure the person's outcomes were achieved as they wished. Staff advised they were always sent a secure email with summary about the person and their needs if the care call was new to them or if the needs and outcomes required had changed.

Staff assisted people with their nutritional and hydration needs as required. We observed staff offering choice and support to have meals and drinks as required. However, several people told us that they had to give guidance to staff regarding cooking as staff did not always have the skills to make simple meals. One person explained, "I do think some of them could do with a bit more support particularly around preparing meals. I am always aware which member of staff it is when I chose what to have for breakfast as some don't know how to cook."

The provider explained that they have initiated visitors logs to encourage health and social care professionals to communicate effectively with them and maintained a communications log at the office to ensure appropriate follow up. They gave an example where they supported a person living with dementia to appropriately access their GP, with the GP seeking feedback from the carers prior to deciding to visit as the person calls the GP frequently due to their memory difficulties. They showed that they had supported people to access services such as community nursing and occupational therapy to optimise their health and manage their health conditions as effectively as possible. The provider had also been involved in multi-disciplinary meetings where the best interests of a person lacking the mental capacity to make a decision had been discussed under the auspices of the Mental Capacity Act (MCA).

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 with appropriate legal authority. I Care provides support to people living in their own homes and therefore applications would need to be made to the Court of Protection. None had been made or deemed appropriate at the time of our inspection.

The provider was aware of the MCA and held records of which people using the service had mental capacity issues and whom had someone appointed to make decisions on their behalf. All the staff interviewed

showed good awareness of the principles of the MCA and were able to explain how they supported choice and autonomy as much as possible, acknowledging the individual's right to take risks and supporting people to make decisions wherever capable. The care plan summaries included an indicator of any issues affecting the person's mental capacity and if anybody else is required to support a person with making decisions. We observed staff seeking consent prior to giving care and noted the signed and dated consent on the care summary held in each person's home visited.

Good

Is the service caring?

Our findings

All the people using the service told us that the staff were caring and treated them with respect. One person said, "I am very happy with the staff and the way they treat me. They will do anything for me. They are very kind." A relative commented, "The staff always treat [my relative] with respect. They are very caring and polite. Some make a great effort to talk about things that are meaningful and interesting to [my relative]." Another person said, "The staff strive to be compassionate and certainly treat me with dignity and respect".

Two people mentioned that their dignity and privacy was not always upheld when two staff were working together as the staff would sometimes talk over the person or would not maintain discretion when supporting with personal care; this was noted particularly where a new member of staff was shadowing the care required. The provider agreed to remind staff when working together to remain focused and respectful of the person requiring care.

Provision of care for complex packages requiring two carers did not always support consistency of carers with new workers often operating as the second carer whilst still in their induction period. This, sometimes, led to a loss of focus on the person requiring care as the staff needed to explain the tasks required. One person commented "they tended to talk over [person requiring support] and weren't focusing on [them]" and another felt the new staff were not always sufficiently skilled to act as the second carer during their induction and that they should be supernumerary. The provider advised that they aim for double teams to always have at least one experienced staff member who knows the person receiving care.

A relative commented that the provider, "Goes above and beyond." to personalise the care, giving an example where a staff member provided a highly personalised surprise for a birthday which had taken considerable thought and effort. The provider advised us they always send people using the service birthday and Christmas cards and that they placed great importance on the attitude of care staff towards people.

One person described how the care supported her autonomy and independence, "I am pretty independent in my wheelchair so don't need much. I just need a bit of help in the shower. They make sure I am safe and support my independence." Staff described the importance of balancing the care required with enabling maximum independence, noting that wherever possible they encouraged participation in tasks, particularly in relation to personal care or decision-making. They also gave examples of supporting people to access the community to minimise the risk of social isolation.

The management advised they aim to visit and review the care provided with each person every three to four months or sooner if required and any changes are communicated to staff via secure emails. People told us they were involved in formulating the care plans and one person said, "I have a care plan and it is up to date. The staff have it on their phone so if they haven't been before it is very accessible to them. The staff walk my dog for me and I think that is even in my care plan."

Good

Is the service responsive?

Our findings

People told us that the provider is usually accessible and responsive. One person told us "The office is easy to get hold of and the people there are easy to speak to". People advised sometimes they get an answer phone but they call back quickly. Several people commented that staff are willing to help, one said, "[the staff] always offer to do anything. I do what I can for now but I know they will help when I deteriorate."

The provider aims to review, with the people using the service, the 'This is me' care summary and care plans three-monthly or sooner if there is a change in circumstances. We saw that staff were provided with updates via secure email when changes were made and the provider could check staff had accessed the changes prior to giving care. Staff were encouraged to document any changes in need and email the issues to the office. For example, one staff member explained they had recently noticed an increase in falls of a person which she relayed to the office. This led to a family meeting and plan of action.

People using the service reported any concerns they experience are usually dealt with well. One person said, "I do know that my [family member] has brought issues up in the past, but they have been dealt with, no problem". Another person told us, "I don't really have issues but if I wasn't happy, I would ring the office. I have rung to ask them not to send a particular carer in the past and she has never been back, so I would say they listen." The provider gives each person a 'Service User Handbook' which details how to raise a concern, complaint or compliment. We found complaints were responded to appropriately verbally and in writing to the people concerned.

People using the service are encouraged to give feedback on the care provided both directly, at reviews and also via an annual anonymous survey. The provider provides a monthly newsletter to people using the service and a detailed analysis and response to the annual survey. These set out changes that have been made in response to issues raised my people using the service.

The provider regularly provides care for people at the end of their life, including care commissioned by NHS Continuing Health Care. The staff induction covered support for end of life care. The provider also had a member of staff with who specialises in end of life care, with additional expertise and training; this staff member works variable hours to accommodate focusing on these cases, as far as practical, to promote continuity of care for people which is much appreciated at these difficult times. The provider demonstrated they were responsive to changes in need and was usually able to quickly provide larger packages of care as a person's needs became more intensive. However, whilst the provider endeavoured to ensure at least one member of a double team would be familiar to the person using the service, feedback from people using the service was that the continuity of staff, particularly for these larger packages was sometimes compromised. This impacted on the quality of emotional support possible and meant the person requiring care needed to explain their changing needs more frequently.

Requires Improvement

Is the service well-led?

Our findings

The feedback from people using the service regarding the management of the service was positive. Several people recalled the registered manager visiting. One person said, "We see [the registered manager] from time to time and she will ask for feedback. I have her number and wouldn't hesitate to call her if I needed to." Everyone we spoke to said they would recommend the service to others, one person saying, "I certainly would recommend them, in fact I already have several times over the years."

The management described how safeguarding incidents had been appropriately managed but acknowledged that a clearer procedure and recording process was required to evidence this work, including their analysis and lessons learnt. They acknowledged that whilst they had reported safeguarding incidents to the local authority they had not notified CQC as required by regulations to enable CQC oversight as the regulatory body. They also acknowledged that they had not been reporting medication errors to either the local authority or CQC as required. They agreed to refresh their understanding of their duties to notify and immediately revised their policy and procedures to reflect this requirement and to include better recording.

We found that quality assurance practices required improvement. Audits were not always systematically managed or recorded to ensure accurate records, analyse practice or drive improvements. For example, we found management had not completed sufficient quality checks on care plans and risk assessments. We found where a change in needs had been identified, changes were made to the case summary paperwork and to the specific individual care plans but the impact on the remainder of the care plans were not always holistically considered or documented. Individual care plans were often not dated so this made auditing case files difficult. It was clear that the three-monthly reviews by management did not adequately check the validity of all the care plans. The management was also not completing regular audits of staff training needs and could not demonstrate thorough management of their training targets. Management explained they logged and reviewed all incidents on their system but that there was not a regular recorded audit to look for themes and ensure appropriate oversight.

The registered manager acknowledged that her provision of a personalised service to people using the service and the staff meant that they did not always prioritise oversight and audits which could support stronger management of the service. However, they had recently recruited an additional assistant team manager and part time training officer, so advised the service is aiming for a better balance of management responsibilities once these staff are fully embedded.

People using the service had regular reviews with management staff and were also sent an annual survey which was anonymously collated, analysed and the outcomes and forthcoming actions sent to all people using the service. Following feedback, a monthly newsletter has recently been commenced to keep people using the service informed of any news and developments and to promote inclusion.

Staff were complimentary of the management of the service. They reported that staff morale was generally good and that the management was approachable, supportive and open to feedback. One commented that management was, "Excellent at following up issues for people using the service." Another said, "[the

management] take on board ideas and feedback on changes." Several experienced staff had worked for other care providers and had chosen to move and stay with this provider citing a variety of reasons including that the provider gave good person-centred care alongside good support and working conditions for its staff. Staff similarly stated they would have, or had already had, relatives supported by the service; One commented, "It's the sense of person-centred care. All the carers treat the client like they'd want their relative treated."

Several staff mentioned that they had been short staffed earlier in the year but that management had worked hard to recruit staff and this was no longer a significant problem. Management explained that they had had a recruitment drive and that to maintain staffing levels they are planning to hold regular recruitment days locally and have initiated a staff reward scheme to promote good practice, improve staff morale and staff retention. Management showed that they had an electronic system which tracked staff's location, including times and length of calls attending each person and that this was audited monthly with an average of 93-97% meeting care call times.

Staff reported that, following successful completion of their probation, they had supervision and/or spot checks on their competency regularly (approximately every four months). This was reported to be monitored by the registered manager but there was not a recorded audit to confirm this. Whilst the provider was not completing formal appraisals they were able to show that they were monitoring staff competencies and supporting staff development. Several staff described being supported to complete additional training such as NVQs or specialist areas such as end of life care. The provider informed us they will be implementing regular appraisals for staff to ensure and formalise consistent support.

Staff had a good understanding of their roles and the structure of the organisation. The role of senior carer which had been introduced earlier this year, was considered a beneficial change with staff able to seek support, including extra shadowing and mentoring as required alongside more frequent competency checks. Staff reported the on-call system was effective.

Staff feedback and records showed that staff meetings were held regularly (twice annually in the last two years with quarterly meetings now scheduled for 2019) and that these meeting included feedback on practice, lessons learnt from incidents and development of procedures and policies. Staff were also sent significant policy updates by email which required read receipts to ensure staff were kept informed.

The provider showed that they worked with partner agencies with a communications log held in the office to track work with allied professionals such as GP, occupational therapy or community nursing. They had also initiated visitor communication books in people's home to encourage better communication with allied professionals, informal carers and family.

Management were knowledgeable and informed about the service they provided and were regularly updating practice following reflection on incidents. For example, the introduction of a medicines officer and separate medicines administration packs for each person was initiated by management and has successfully redressed past concerns about the frequency of medicine administration errors. Another example of the management striving to improve the service was the revision of the staff induction to include practical training in the management of catheters and stomas following feedback from both people using the service and staff.

The registered manager attended regular local care provider meetings to maintain and develop their knowledge. For example, the recent introduction of proforma, 'This is me' and summary page for each person using the service which encouraged person-centred care and knowledge of the individual, was

adapted from one showcased by an "outstanding rated provider" at one of these meetings. The provider had commissioned a mock inspection by an external provider to aid service development and had an ongoing service development plan.

The registered manager was commendable in their openness and commitment to the CQC inspection process and promotion of good practice.