Prosper Community Care Limited

Prosper Community Care - York

Inspection report

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Date of inspection visit:
13 January 2017
18 January 2017

Date of publication:
07 March 2017

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 13 and 18 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location office when we visited.

Prosper Community Care York is a domiciliary care agency that provides support to people who live in their own home, both adults with disabilities and older people. They provide services to people in the York area and the office is based in York. At the time of our inspection eight people were receiving support from the service. The service was registered in March 2016, so this was their first inspection.

The service is required to have a registered manager, and at the time of our inspection 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.

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns.

We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm.

Recruitment processes ensured staff were suitable to work with vulnerable people. Staff received an induction and told us they had the training, supervision and support they needed to carry out their roles. The registered manager promoted a positive and person-centred culture.

Where staff supported people with their medicines, we found that this was recorded on medication administration records (MARs). Staff had received training in administering medicines and the registered manager checked MARs when they conducted quality assurance spot checks at people's homes, to ensure they had received their medicines as prescribed.

The registered provider sought consent to provide care in line with legislation and guidance. We found that people had signed their care plans to give their consent to the care they received. The registered manager agreed to record details in people's care files where anyone had a Lasting Power of Attorney (LPA) for health and welfare. Staff completed Mental Capacity Act (MCA) training as part of their induction training and were able to demonstrate an understanding of the principles of the MCA.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as district nurses. People were also supported with their

nutritional needs, where this was part of their care plan.

Most people we spoke with told us that the staff who supported them were kind, caring and respected their privacy and dignity. We observed staff delivering respectful and attentive care.

All people who used the service had a care plan which contained information about people's needs, routines and preferences. These were regularly reviewed. We found some examples where care plans lacked detail in certain areas, such as in one person's care plan regarding communication needs. However, most care plans contained sufficient detail and were person centred. Staff were able to demonstrate an understanding of people's needs and preferences.

There was a complaints procedure in place and people who used the service and relatives told us they knew how they could raise a complaint if they needed to, and would feel comfortable doing so. One relative had an outstanding concern and the registered manager responded to this shortly after our inspection visit.

There was a quality assurance system in place and the registered manager regularly visited people to check the care that staff provided. However, these checks were not always documented and the quality assurance system required further development and improvement to ensure the registered manager had a robust system for identifying issues and assessing the quality of the care. We have recommended that the registered provider seeks guidance from an appropriate source about best practice in quality assurance systems and audits, and develops their systems accordingly.

The majority of people and relatives we spoke with were very satisfied with the service they received and told us that staff were reliable, usually on time and provided care in line with their wishes and preferences.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were systems in place to protect people from avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to report any concerns.

Recruitment processes ensured staff were suitable to work with vulnerable people.

There were systems in place to ensure that people received their medication.

Is the service effective?

Good

The service was effective.

Staff received an induction and told us they completed the training they needed to carry out their roles.

Staff were able to demonstrate an understanding of the principles of the Mental Capacity Act, and the importance of gaining consent before providing care to someone.

People were supported to maintain their health and access healthcare services.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and we observed staff demonstrating respectful and attentive care.

People we spoke with felt that staff involved them in decisions about their care, and relatives told us that staff respected people's privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were developed to enable staff to provide personalised care. Staff demonstrated an understanding of people's individual needs and preferences.

There were systems in place to manage and respond to concerns and complaints.

Is the service well-led?

Requires Improvement

The service was well-led, but some areas required improvement.

The registered manager promoted a positive and person-centred culture and staff were provided with the support they needed to deliver the service.

The registered manager conducted spot checks to assess the quality of the service but these were not always documented. The quality assurance system was insufficiently developed to ensure it was fully effective in assessing all areas of the service.

Prosper Community Care - York

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 took place on 13 and 18 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection was conducted by one adult social care inspector.

Before visiting the service we reviewed information we already held, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also received feedback from the City of York Council's contracts and commissioning team.

The registered provider was not asked to complete a Provider Information Return (PIR) prior to this inspection. This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with four people who used the service, four relatives of people who used the service, three care staff and the registered manager. We looked at five people's care records, three care staff recruitment and training files and a selection of records used to monitor the quality of the service. We visited the agency office, and following this we spoke on the telephone with people who used the service. We also made a home visit to speak with someone who used the service and looked at the information available to care staff.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe with staff and the support they provided; people confirmed they did. One person gave us an example by telling us how gentle staff were when supporting them to reposition and use their hoisting equipment. A relative also told us, "The carers are brilliant… They are very vigilant."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. There was a copy of the local authority's multi-agency policies and procedures available for staff to refer to. All staff received training in safeguarding vulnerable adults from abuse as part of their induction training and we were advised that staff would receive annual refresher training when this was due. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns. No safeguarding referrals had been made since the provider had registered the service with us in March 2016, but the registered manager understood their responsibilities in relation to safeguarding and was aware how to manage any potential safeguarding concerns. The registered provider also had a whistleblowing policy, which was available for staff to refer to. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

The registered provider completed risk assessments in relation to people's individual needs. These included moving and handling, medication and a health and safety risk assessment which considered environmental risks within the person's home. There was also a risk assessment which assessed dependency levels in relation to specific moving and handling and personal care tasks. The registered manager acknowledged there was some duplication in these documents and on the second day of our inspection showed us a new risk assessment format they had developed, in order to consolidate some of the information in to one assessment. This document also had additional information about nutritional, medication and pressure sore risks.

The registered provider had an accident and incident policy, which included recording details of any accidents or significant incidents on a form, so that the registered manager could ensure appropriate action had been taken. There was only one incident recorded on file, which showed that the incident had been managed appropriately. Staff had responded promptly and involved other relevant agencies when they had been concerned about a person's well-being and safety. This prompt response meant the person received the emergency assistance they needed and prevented them being left at significant risk. The registered manager confirmed there had been no other accidents, injuries or significant incidents since the service was registered.

Staff were able to give us examples of the support they provided to ensure people were safe, including being vigilant to changes in people's condition, ensuring people took their medicines and securing people's property before leaving. We saw from minutes of a recent team meeting that the focus of the meeting had been a discussion about winter planning. Reminders were given to staff about paying particular vigilance to

people's needs at this time of year, including supporting people to set the right heating temperature in their homes and notifying the local authority if there were any difficulties getting to people due to bad weather conditions.

We looked at recruitment records for four staff. We saw that appropriate checks were completed before staff started to work at the service. These checks included seeking references, obtaining proof of identification and interviewing candidates. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safer recruitment decisions and prevent unsuitable people from working with vulnerable groups. In two staff files that we viewed the registered provider had recorded the DBS check reference number on file, but not the date they had received it. The registered manager agreed to add these dates, and told us they now used an online DBS check system which automatically showed the date the check was completed alongside the number, so they printed out and retained this information. This was confirmed by the other two recruitment files we viewed. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We talked to the registered manager and staff about whether there were sufficient staff to meet people's needs and ensure all care calls were attended in line with each person's care plan. The registered provider completed an initial assessment of people's needs, prior to providing support to them. Where someone was funded by the local authority the service received information about the person's needs from their Social Care Assessment, which enabled the registered manager to plan the staffing required. At the time of the inspection there was a small staff team of five regular care staff and the registered manager, to support the eight people who used the service. In addition, the registered provider used care staff from their other branch in Stockport to support the York service where required. We were told that because staff worked with a regular group of people, the registered manager did not use a formally recorded rota system to allocate call visits. The staff team met each morning to discuss planned visits and agreed any changes with the registered manager so they were able to ensure all call visits were appropriately covered. The registered manager acknowledged that if the service were to grow and take on more clients they would need to develop a more formal rota system.

People and relatives we spoke with told us that staff were reliable and usually arrived at the time they were expected to. One relative told us they felt the time of their relation's evening visit was too early. The registered provider confirmed shortly after the inspection that they had met with the person and family and agreed a later visit time. People also confirmed that staff stayed the right length of time. One person told us, "They don't always have time for a long chat because they have jobs to do, but they do have a chat and they always have time to explain things. I'm happy with that."

There was a 24 hour 'on-call' system which staff or people could use if they required assistance or support out of hours. Staff confirmed to us, "We can reach the manager at any time." They told us that the registered manager also worked alongside them to deliver care if this was ever needed.

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers of staff to meet peoples' needs.

The registered provider had a medication policy in place and staff received training in medicines management as part of their induction. The registered provider confirmed that medicines management training would be refreshed annually for all care staff, when this was due. The registered manager checked medication administration records (MARs) when they visited people's homes to conduct quality assurance

spot checks on staff. Any issues with MARs were noted on spot check records. However, there were no formally recorded routine medication audits. We have made a recommendation about quality assurance audits in the 'well led' section of this report.

People's individual care files contained details of any support required with medication, along with medication consent forms in which people had signed to give their consent for staff to assist with their medicines. We looked at one person's MARs when we visited their home, which were completed and showed that the person had received their medicines, as supplied in pharmacy packed blister packs. We noted that the registered provider did not have a list of all the medicines the person was currently prescribed, as their repeat prescription from the GP was automatically sent to the pharmacy. This meant that the registered provider was reliant on the pharmacy having filled the blister packs correctly, rather than being able to double check this for themselves. However, the registered manager told us that they were currently working with the local authority to look at the most appropriate way to manage this person's medicines safely, and this was later confirmed by an officer at the local authority.

The person we visited confirmed they were happy with the support they received from staff with their medicines and told us, "They [staff] always remember to give me my tablets."

This showed us that there were systems in place to ensure people received their medicines and thar the registered provider was actively working with partners to minimise risk in relation to medicines practice.

Good

Is the service effective?

Our findings

We asked people who used the service whether they were happy with the care they received and whether they thought staff had the right skills for the job. People's comments included, "They are very good" and "They know what they are doing when they come." One relative told us, "The carers are brilliant" and "Yes, they have the right skills to do the job…They are confident." Another relative told us, "I can't speak for other people, but they certainly have the right skills for my [relative]."
The registered provider had an induction program for staff which covered health and safety, food hygiene, infection control, moving and handling, first aid, medicines awareness and safeguarding vulnerable adults. The induction also covered the registered provider's values and ethos. Where staff had already completed recent training courses with previous employers, the registered manager retained evidence of this in staff files.

The registered manager monitored when staff were due to complete refresher training, as records were held electronically on a training matrix. We did, however, note there were some recording errors on the matrix as the dates of one person's induction and training had been incorrectly entered. The registered manager addressed this straightaway. Staff told us, "When I joined I completed an induction, including moving and handling, first aid, food safety and safeguarding. I have worked in care before. We can discuss with the manager if we want any extra training and they would organise it." Another staff member said of the training provided, "So far, so good. If there is a need for anything, such as medication training, [Registered manager] organises it for us."

We saw evidence of staff supervision and team meetings; both covering a range of appropriate topics. Topics discussed in recent team meetings included reminders about infection control and personal protective equipment, training, policies and procedures and individual issues in relation to people who used the service. The registered manager also completed quality assurance spot checks, to observe staff practice. This showed us that people received care from staff that had the knowledge and support they needed to carry out their roles.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the registered provider was working within the principles of the MCA. We saw evidence that people had been involved in decisions about their care and had signed to consent to their care plan. People had also signed forms to consent to staff supporting them with their prescribed medications were

this was applicable. The registered manager agreed to add details into care files where people had a Lasting Power of Attorney (LPA) for health and welfare.

Staff completed MCA training as part of their induction. They were able to demonstrate an understanding of the principles of the MCA and the importance of gaining consent before providing care to someone. Staff told us, "You need to assume everyone has capacity, and if not there should be discussions with others around making decisions on their behalf and in their best interests. Everybody we support at the moment has capacity (in relation to decisions about their care)" and "We always ask how people want something done and when/where." Another staff member told us, "Just because someone had an illness or disability doesn't mean they can't make a decision. You need to help them understand the decision to be made, explain things and respect their choices. If they are not able to make a decision this is when you'd need to involve the manager and others in assessing their capacity." This showed us that staff sought consent to provide care in line with legislation and guidance.

We looked at the support people received with their nutritional needs. Some people who used the service required support with meal preparation and drinks. People's care file contained a section about their dietary needs and the support required from staff. We viewed one file which contained detailed instructions for staff about the support the person required with their meals, including the requirement for adapted crockery, cutlery and drinking aids. There was information about the drinks that staff needed to make available for the person to access during the day. When we visited the person's home we observed that staff were following the care plan appropriately, in order to ensure the person received sufficient food and fluids.

One person received nutrition via PEG feeds, but support with this was provided from their family rather than staff at the service. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the abdominal wall and into the stomach. PEG allows nutrition, fluids and/or medicines to be put directly into the stomach. The person's relative told us that staff were very attentive and even though they weren't responsible for the PEG, they had good awareness of the importance of it. They gave us an example of an incident during an overnight care call. The staff member noticed an issue with the PEG tube when they were checking on the person and they alerted the relative straightaway. The relative told us the staff member's vigilance and swift response had prevented further complications and the person potentially having to be taken into hospital.

One relative we spoke with did not feel staff encouraged their relation enough with eating. They recognised the person had the capacity to choose for themselves and decline food, but felt staff could do more to try to persuade them to eat. We discussed this with the registered manager, and they updated us following our inspection to confirm that they had met with the family to discuss how they may be able to provide more encouragement to the person with their eating and drinking.

People were supported to maintain good health and access healthcare services. Care plans contained a section in relation to health and well-being and we saw that contact details of relevant healthcare professionals, such as district nurses, were available for staff to refer to. There were instructions in care files where people needed more specific assistance to monitor and maintain good health, such with their as skin integrity. One person was supported to attend all their health appointments by care staff, but other people had family members who were able to assist in this area. Contact with any healthcare professionals was recorded within daily logs in people's care files. The registered manager told us they were planning to introduce a separate log for contact with professionals, in order to make it easier to track any contact and the outcome of this.

Good

Is the service caring?

Our findings

We asked people who used the service if staff were caring and the feedback we received was positive. One person told us staff were kind and said, "It's usually the same people (staff) that come. It's nice because we've built up a relationship now." Others told us, "They (staff) are very nice" and "They're fine."

Most relatives were positive about the caring manner of staff. One told us, "They (staff) are definitely kind and caring. They are lovely and always have a smile of their face." They continued, "They always do extra. They provide waking night support twice a week, and they always do my ironing and have a tidy, but they don't have to." Another relative told us, "[My relative] has two regular carers. [My relative] treats them like family and they do the same back. You can see it's a genuine affection."

One relative also told us, "There is good communication. They (staff) always speak to [Name], not over them. They have a laugh together. They understand [Name's] needs and preferences. [Name] has some communication difficulties but they understand them." They told us about specific body language and gestures the person used to indicate certain wishes, and told us staff were "Really good" at noticing these and responding accordingly. Whilst conversations with relatives, staff and people showed us that staff understood and responded well to people's individual means of communicating, we noted some care files were lacking in detail about people's communication needs to ensure all staff had clear information in order to promote consistency of approach.

We observed staff supporting someone in their own home, and interactions were warm, positive and respectful. Staff asked the person's view on things, such as what they wanted to watch on television and whether they were happy with the volume. Staff were attentive to the person's needs and offered assistance with tasks where this was required. The person appeared comfortable and relaxed in the presence of staff.

Most people we spoke with told us they had choice and control about their care and felt their views were acted on. One person told us they did not feel they needed evening calls and were unhappy about this. However, we were advised that the person's family and social services had assessed the situation and that evening calls were required for the person's safety. We were told that discussion with the person about this was underway. Other people told us, "They (staff) listen to me. I can say if I don't want something." Relatives told us that staff respected people's choices, and one gave us an example to illustrate this; "My [relative] didn't feel like a shower this morning and staff didn't push them on this, they respected their wishes." Staff described how they offered and respected people's choices, and the importance of supporting people to understand the decisions they were being asked to make. It was evident from people's care files that people had been involved in decisions about their care and had signed their consent to the care they received.

We discussed with staff how they met people's needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people who used the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. Staff received training on equality and diversity within their induction. People

were provided with support to practice their religious faith where this was part of their care plan. One person whose care file we looked at stated that staff were to support the person to attend their local church on Sunday. When we spoke with this person they confirmed that staff supported them to attend church and said, "They help me in church very well indeed."

Staff described how they delivered support in a way that encouraged people's privacy and dignity, especially when providing support with personal care, such as showering and bathing. This included ensuring people's curtains and doors were closed and keeping people covered when washing them. One relative told us that staff respected their relation's privacy and dignity and gave us an example of how they did this. They said, "If [relative] starts to get undressed in the sitting room they discourage them and guide them to their bedroom instead." Another relative told us that having the same regular carers enabled their relation to feel comfortable, and commented, "You never get (staff) you don't know."

Good

Is the service responsive?

Our findings

All people who used the service had a care plan, which they had been involved in developing and reviewing. One person told us, "They support me in the way I want. They know what I like and don't like." Relatives we spoke with also told us they were involved in the development of people's care plans and reviews of their care.

The registered manager completed an assessment of people's needs. This included an assessment of needs in relation to health and wellbeing, activities, communication, mobility, personal care, continence, skin care, medication, diet, community access, eyesight and hearing. The registered manager then worked with people to build up a care plan, which detailed the support they required in each of the areas outlined in the assessment. We found care plans were generally detailed and person centred, although one person's care plan lacked detail with regard to communication and sensory needs. We also noted a small number of minor recording errors in care plans, such as date errors and missing signatures. The registered manager agreed to address this. Care plans included some detail about people's preferences in relation to food, personal care and how people liked to be supported with particular tasks. Care plans were reviewed regularly.

Staff we spoke with were aware of people's needs and preferences and understood the importance of providing care in line with people's wishes. One told us, "When we work with people it is not about us, it's about the people we work with and what they want. Most people I've worked with a long time, so I know what they prefer."

Staff completed a log sheet at each care visit, with information about the time of the call, any food and drinks provided and the care delivered. The log sheet also prompted staff to confirm that they had completed medication records. We saw from log sheets that staff provided support in line with people's requests. For instance, there was an entry that stated a person had expressed a wish to go out to the shops, which staff had supported them with. The entry stated how much the person had enjoyed their visit to the shops.

Most relatives told us that staff were very responsive to people's needs. For example, one relative told us that when their relation had a pressure sore after a period of ill health in hospital care staff helped them manage it. They said, "Staff were brilliant at helping me heal it. We had to always change [Name] straight away and staff were always great. They always tell me straightaway if [Name] has any marks, as their skin is quite delicate, so they always show me." They also told us that on occasions they requested extra call visits at short notice, due to unforeseen events, and the registered manager arranged staff in order to accommodate this.

Where it was part of someone's agreed care plan, staff provided support with social and leisure activities. We saw evidence in care files that people were able to choose the activities they wished to do, and examples included going to the shops, yoga sessions and massages. Where staff provided support with community and leisure activities they completed details about this on an activity sheet, which was held in the care file in

people's homes.

This showed us that people received personalised care that was responsive to their needs.

There was a complaints procedure in place and a system to record and respond to these. The compliments, comments and complaints procedure was available to people who used the service, within a 'Service User Involvement and Information' file which they were given when they started to use the service. Records showed that no formal complaints had been received since the service was registered in March 2016.

People and relatives we spoke with told us they would feel confident raising a concern or complaint. Most told us they would speak to the registered manager. One relative told us they had outstanding concerns which they did not feel had been resolved. They said these were in relation to support with nutrition, cleaning and visit times. The registered manager updated us shortly after our inspection to confirm they had met with the family to discuss the issues. Other people and relatives we spoke with told us they were confident that any concerns they raised would be listened to and addressed. One person told us, "I would tell [Registered manager] if I had any concerns. They would listen to me and be supportive of me." Relatives told us, "I would be happy to ring the manager" and "I would definitely feel comfortable ringing [Name] and I'm confident they would deal with it. In the past, when a carer left, we had a few different carers for a short while which I spoke with [Name] (registered manager) about and they sorted it. Now we have regular carers.

We found that people also had opportunity to comment on the care they received in their review meetings and when the registered manager conducted spot checks on the quality of the service.

This showed us that concerns and feedback were encouraged and that there was a system in place to respond to complaints.

Requires Improvement

Is the service well-led?

Our findings

A registered manager was in place as required under the conditions of their registration with the Care Quality Commission (CQC). They were also registered as the manager for a service provided in another area. However, the registered manager told us they spent the majority of their time at the York branch. The registered manager understood their role and responsibilities towards the people who used the service and staff. They also demonstrated an understanding of their legal obligation to notify the CQC about important events that affected people using the service and the running of the service.

The registered manager held a Registered Nurse Learning Disability (RNLD) qualification. They explained their vision for the service and how they planned to achieve it. They told us they only intended to grow in size once they had the infrastructure and systems to support a larger number of people, as they wanted to focus on the quality of support people received. The registered manager worked with three other registered providers to share best practice, offer support and pool practical operational resources, like training. This helped to improve efficiency and meet the needs of people who used the service. The registered manager told us they kept up to date with best practice and legislation via information from the local authority, completing training and receiving bulletins from the Independent Care Group (ICG). They told us they shared key information about best practice with staff in team meetings.

Staff received supervision and attended team meetings, and told us they were well supported by the registered manager. Their comments included, "At the moment we work with the manager regularly. They are on hand to help us and will talk to us. They come to do spot checks and we see them every week. I enjoy working alongside [Name] and we get massive support." Other staff told us, "[Name] does spot checks and we get supervision…I find the supervisions useful" and "We get support from [Name] whenever we need something… I talk almost daily to them."

Staff described the values of the company and told us it was "Person centred," had a "Family approach" and was "A good company to work for." The staff felt they worked well together as a team. This showed us the registered manager promoted a positive and person-centred culture.

The registered manager conducted spot checks to assess the quality of care that staff provided. We saw records of these spot checks in staff supervision records. They assessed if staff were punctual, wore appropriate uniform, used personal protective equipment, and had a professional friendly approach. They also assessed if staff were familiar with people's care plans and involved people in tasks. There was a section for the registered manager to check and document if medication records were completed appropriately, medication errors were logged and staff understanding in relation to medication tasks. In addition, the registered manager documented feedback from the person about the staff member and the care they provided, and this was signed by the person. We found that feedback was positive.

We found that two spot check visits were recorded for most staff in the last six months, but from discussion with staff and people who used the service it was apparent that the registered manager visited people and assisted with care delivery more often than this, but had not always recorded the checks conducted at these

visits. From the records we viewed it was difficult to track evidence of action identified and taken as a result of spot checks, because sometimes minor issues had been identified and addressed informally, without being recorded. For instance, we saw in a supervision record that improvements had been noted with regard to one staff member's record keeping, but there was no record of the initial concern and what action was required to address it. Discussion with one relative showed that they had raised a concern informally; this had been addressed but was not recorded.

There were no formal audits of the quality of care plans, which would have helped the registered manager to identify and address the minor recording errors we found in the care files. Whilst the registered manager told us they regularly checked medication records when they visited people's homes, there was limited evidence of this; only the spot check records in staff files. Although we did not find any evidence that people's care had been impacted by these issues, and most people were very satisfied with the care they received, we found improvement was required to the governance and quality assurance systems. This was because record keeping in relation to quality monitoring was not always clear and consistent and did not demonstrate how quality assurance processes and audits were helping to identify and drive improvement in the service.

We recommend the registered provider seeks guidance from an appropriate source about best practice in quality assurance systems and audits, and develops their systems accordingly.

The registered manager told us they were very committed to providing a high quality service and ensuring they had robust quality assurance systems before they considered expanding the business. They also told us that, as a relatively new provider in the area, the local authority had been supportive in working with them to achieve this.

Most people we spoke with were happy with the service they received, and one person told us, "I'm satisfied with them (staff). I like them very much." Relatives we spoke with told us, "I'm just so glad we've got a good care company now. We have had others that have messed us about but these are so good" and "My [relative] is very satisfied with the care they provide."