Direct Care (UK) Limited

Direct Care - Leicester

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

This inspection took place on 6 & 7 July 2017 and was announced.

Direct Care – Leicester is registered to provide personal care and support for people living within their own homes. At the time of our inspection there were five people using the service, some of whom were older people some of whom were living with dementia, people with a physical disability and people receiving end of life care. People were supported who had a learning disability and or autistic spectrum disorder.

This was the first inspection of the service since it was registered on 20 July 2015.

Direct Care – Leicester had 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.

People's safety and welfare was promoted, which was confirmed by the completed surveys sent out by CQC. Safety and welfare was fully understood by staff who had received training on their role in protecting people from risk. Safety and welfare was further promoted through comprehensive assessments and on-going review of potential risks to people. Where risks had been identified measures had been put into place to reduce the likelihood of risk and were recorded within people's records and understood and implemented by staff.

Staff upon their recruitment had their application and references validated and were checked as to their suitability to work with people, which enabled the provider to make an informed decision as to their employment. Staff underwent a period of induction and training, which included them being introduced to people whose care and support they would provide. Bespoke induction and training provided to staff and staff understanding of their role and responsibilities meant people were supported appropriately with all aspects of their care, which included support with their medicines in the management of their health conditions which promoted their safety and welfare.

People's needs were effectively communicated and recorded and understood by staff, to ensure people's needs were met. Staff communicated immediate changes or concerns to people's health or welfare with those involved in a person's care through the use of technology available through their mobile phone. This ensured staff were able to take the appropriate action to meet people's needs. Staff had access to support from a member of the management team at all times.

Staff understood the importance of seeking people's consent prior to providing care and support. Staff were aware of people's rights to make decisions and were able to tell us how they encouraged people to express their opinions on their care and support. Staff were proactive in liaising with health care professionals and followed advice and guidance as detailed within people's care plans. People received support with the

preparation, cooking and eating of meals where needed to ensure people's nutritional needs were met.

People's records, including their care plans had been developed with the involvement of themselves or their relatives and provided information for staff about the person. The information was used to develop positive and professional relationships when delivering personal care and support when undertaking social activities and were reflective of people's wishes and preferences. Staff fully understood and were committed to providing the care and support reflective of people's preferences, which included staff understanding people when their communication was non-verbal. The person we spoke with was positive about the attitude and care of staff, stating they received support and care from a consistent group of staff. This was confirmed by the surveys completed by people using the service, community professionals and staff.

The care and support people received was very individualised and person centred, taking into account their specific needs which enabled staff to provide a responsive service to support the achievement of people's goals as detailed within with their care plans. Changes to people's needs were planned for and fully documented. The registered manager responded to people's comments, concerns and complaints and was reflected in the records we looked at, including the surveys sent out by CQC. Information on how to raise a concern or complaint along with contact details for external agencies was made available to people when they commenced using the service.

The open and inclusive approach adopted by the provider, meant people using the service, staff and those employed by external services, such as health and social care were confident to liaised with the registered manager and staff about the service provided. This was reflected in people's comments and the information we obtained by speaking to staff members and reviewing the surveys sent out by CQC.

The provider's commitment to the continual development of the service and its aim to continually improve the quality of care it provided meant the provider continued to invest and identify areas for further development and improvement. The provider had attained accredited awards in quality management and health and safety, which were audited by external agencies to ensure compliance.

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 as they were provided with information to raise their awareness and were supported by a registered manager and staff who understood their responsibilities in referring concerns of potential abuse to the relevant agency.

Risks to people's health and wellbeing were comprehensively assessed and were supported by tailored plans to promote people's individual's health, safety and welfare.

There were sufficient numbers of staff available to keep people safe who were knowledgeable as to their role and responsibility in delivery care safely. Safe recruitment systems were followed to ensure staff were suitable to work with people who used the service.

People received support with their medicine which was managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff that had the appropriate knowledge and skills, which included training specific to meet people's individual needs. Staff were employed to provide people's care and had a comprehensive understanding of their needs.

The registered manager and staff understood their role in promoting people's rights and choices in all aspects of their care and support. People had an agreement in place which outlined what they could expect from the service.

People were provided with support, where required, to meet their dietary requirements.

People were supported by staff who liaised effectively with health care professionals, to promote their health and welfare.

Is the service caring?

Good

The service was caring.

People were supported by a consistent group of staff who they had developed positive and trusting relationships with.

People or their representatives were involved in the development and reviewing of care plans, which fully reflected their individualised needs and the outcomes they expected their care to provide.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to receiving a service and were regularly reviewed. People's assessments of their needs were used to develop person centred care plans. People received a flexible service based on changing needs and preferences, which meant they received a bespoke service. People and their family representatives were involved in decisions about people's care and support needs.

People's concerns and complaints were listened to and acted upon and used to develop the service being provided.

Is the service well-led?

Good

The service was well-led.

People using the service and staff views were actively sought about the service. The registered manager used information gathered from people using the service and the consultation of staff to promote good quality care.

The registered manager invested in its staff by providing high quality training, and through on-going supervision and appraisal, which enabled staff to provide good quality care for people.

The provider had attained accreditation for its systems to monitor and manager quality, health and safety.

Direct Care - Leicester

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 checked 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 6 & 7 July 2017. Both days were 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 office to meet with us.

The inspection was carried out by one inspector.

Before the 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. The provider returned the completed PIR.

Prior to our inspection we sent out surveys to seek people's views. We sent out two surveys to people who used the service, of which one was returned. We sent 15 surveys to staff of which four were returned. We sent two surveys to family members of those using the service of which none were returned. We sent 10 surveys to community professionals of which four were returned.

We contacted commissioners for social care, responsible for funding some of the people that use the service and asked them for their views.

We sought the experience of one person who used the service by meeting and speaking with them in their home. We spoke with a family representative of one person who used the service.

We spoke with the registered manager who was also the provider [nominated individual], the finance manager, the learning and development manager and three members of staff.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which the provider is required to send us. We used this information to help us plan this inspection.

During the inspection visit we looked at the care records of three people who used the service. These records included care plans, risk assessments and daily records. We also looked at recruitment and training records for three members of staff. We looked at the provider's systems and records associated with their monitoring as to the quality of the service, We looked at complaints and concerns, minutes of meetings, and a range of policies and procedures.

Good

Is the service safe?

Our findings

The person we spoke with who used the service told us they felt safe in the care of staff and had knowledge about abuse and how the suspicion of abuse was to be reported.

People were provided with a copy of the service user guide. This contained information on the provider's responsibility to promote people's safety and the assessment of risk. It also included information about safeguarding. For example, the provider had a policy which was shared with people using the service which advised them that staff were prevented from accepting presents or gifts from people or entering into private care arrangements, to protect them from financial abuse. This showed a commitment by the provider to promote people's understanding and awareness of their safety.

People's comments within the CQC surveys that were returned reflected complete confidence that people felt safe from abuse or harm from care staff, and was supported by the surveys completed by community professionals. Staff comments within staff surveys reflected their confidence in raising concerns should they suspect abuse. Staff also referred to the provider's lone working policy which promoted their safety as clear protocols were in place, which were followed.

People were protected from harm because staff had received training in recognising and reporting abuse. Staff told us they had attended training in safeguarding people. They also confirmed they had access to the provider's policies on safeguarding adults and children and whistle blowing. Staff understood how to recognise the signs that might indicate someone was being abused. Staff we spoke with had a clear understanding of the different types of abuse, what to look for and how to report it. Staff we spoke with were able to tell us how to report any concerns.

The registered manager had been proactive in the promotion of people's safety and welfare by referring safeguarding concerns to the local authority, where they believed people were at risk. Any safeguarding concerns were clearly documented within people's records and the responsibilities of staff were clearly documented within people's care plans. The registered manager had fully documented all action they had taken to promote people's safety.

Staff received training on the promotion of people's safety, which included receiving training on the safe moving and handling of people, emergency first aid, health and safety, epilepsy awareness and the management of behaviour which may challenge. Risk assessments were comprehensive and reflected a wide range of topics and were supported through the range of training staff had received in promoting people's safety and welfare.

The commitment of the registered manager and staff was to promote people's safety, whilst not being risk adverse, care staff were trained to enable people using the service to extend their independence with positive risk taking. For example, by encouraging people to undertake as much of their personal care as they could for themselves, or supporting people to access activities within the community which they enjoyed.

People's care records included risk assessments which identified risks in relation to their health, independence and wellbeing. The risk assessments were regularly reviewed, updated and incorporated into care plans. They were comprehensive and individualised, and focused on people's particular needs. For example the promotion of people's health by the promotion of people's skin integrity where they were at risk of developing pressure sores, this included a diagram of the person, highlighting the areas of the person's body that were at risk. Where more than one member of staff was involved in a person's care, for example when moving and handling people by the use of equipment, the individual role of staff was detailed, which promoted a consistent approach by staff to people's safety. Comprehensive and individual risk assessments were also in place and were reflective of the activities people took part in, such as accessing the wider community along with people's emotional needs and well-being.

An example of protecting an individual's safety was for a person who was not able to communicate verbally and had regular epileptic seizures. The risk assessment was supported by a care plan and emergency care plan, detailing the care the individual required should they believe the person was about to have a seizure. The person required specialised support, which meant staff had to take immediate action. Staff we spoke with were able to tell us about the medical technology involved and how this worked, which included the steps they needed to take to reduce the likelihood of the person having a seizure. This demonstrated that staff had the knowledge and understanding as to their role and responsibility in reducing risk and keeping the person safe.

The promotion of people's safety included where people had difficulty with mobilising around their home and required mobility equipment. Risk assessments looked at whether there was sufficient space for those using the service and staff to use the equipment safely. People's risk assessments prompted staff to visually check any equipment for potential faults to promote people's safety. We found an example of how staff vigilance had promoted a person's and staff safety. A member of staff had noted a fault with a person's electrical hoist; guidance was then put into place with immediate effect, which instructed staff to use the manual hoist, until it could be repaired. We spoke with a person, who told us how they had initially been reluctant to have equipment installed into their home. They told us they had been fully consulted and had commented that it had improved the quality of their life and improved their independence and safety.

All accidents and incidents were closely monitored and analysed. Reports of incidents gave a clear and detailed account of what had happened and a description of any injuries. The reports also specified who the incident had been discussed with and what actions needed to be taken to prevent further occurrences. As a result of accidents and incidents analysis, people were referred to appropriate specialist services. For example, people were referred to a GP or a specialist nurse. Safety issues associated with a particular incident were discussed at supervision and staff meetings.

The provider had an extensive business continuity and disaster recovery plan covering potential local and national situations and events, such as a power failure, flood or fire. This, if activated would mean the provider, registered manager and staff would take measures that would enable them to provide support and care to people to keep them safe.

The provider and registered manager were committed to the promotion of staff safety and welfare, providing the appropriate training and equipment to promote their safety. Each member of staff was provided with a uniform and identification badge. Staff were provided with protective equipment which included gloves and aprons, alcohol gel, first aid kits and a mask to be used in the event staff were required to provide Cardio Pulmonary Resuscitation (CPR). Staff were also provided with a personal alarm which incorporated a torch.

There were sufficient staff with suitable skills and knowledge to meet people's needs. The number of staff required to meet people's needs was kept under constant review. A high number of staff was provided to support some people's needs and their lifestyles, to ensure they were safe and their needs could be met both at home and when accessing the community. Staffing levels were flexible so that people had the opportunity to go out when they wanted and try new experiences. We saw evidence that staffing levels had been increased to enable staff to support people in accessing the wider community.

We looked at staff records and found people's safety was supported by the provider's recruitment processes. Staff records contained a completed application form, a record of their interview and two written references. A criminal record check had been carried out by the Disclosure and Barring Service (DBS). DBS checks help employers to make safer recruitment decisions by providing information if a person's has a criminal record. This meant people could be confident that staff had undergone a robust recruitment process to ensure staff were suitable to work with them.

People could be confident that their medicines were organised and administered in a safe, competent manner. Staff had received specific training and supervision in medicine management. Some people required their medicine to be administered by staff, whilst other required prompting and monitoring or were supported by family members. The registered manager and care co-ordinator undertook regular competency checks on staff to ensure they followed safe practices when people were being supported. Staff also left messages for each other if they had any special instructions or if there had been changes to the person's medication.

People's records included information as to the medicine a person was taking, why the medicine had been prescribed and potential side effects to be aware of. Information was also provided as to the location of people's medicines within their home. Where people required creams to be applied, there were clear and comprehensive instructions provided as to where the cream was to be applied and the circumstances, in which, for example after a person had received personal care. There were protocols in place for the administration of medicines that were prescribed on an 'as required' basis (PRN), which included 'rescue' medicines, which were to be administered as a result of an event, such as an epileptic seizure. The comprehensive documentation within people's care plans promoted their safety as it provided clear guidance for staff to follow.

The evidence we found supported the information submitted by the registered manager within the PIR.

Good

Is the service effective?

Our findings

The provider ensured all staff were provided with excellent training and development opportunities. This support enabled staff to put their learning into practice to deliver care that met people's individual needs. People benefited from a skilled staff team; high quality training and support for staff ensured a high standard of care. Training was delivered in a range of ways. The learning and development manager was employed to provide training for staff and they told us how training was both practical and theoretical. Health care professionals provided training where required to meet people's specific care needs. In addition staff accessed training on-line. The registered manager had identified from feedback and reviews that the focus on quality training had helped with staff retention.

People's comments within the CQC surveys that were returned reflected fully that people received care and support from consistent staff, who arrived on time and had the necessary skills and knowledge to meet their needs. People stated staff stayed the agreed length of time and completed all tasks as identified within their care plan. The surveys completed by community professionals, reflected they would recommend the service to a member of their own family, and that they had received feedback from people who stated they were happy with the service provided by Direct Care- Leicester. Community professionals also commented that staff were competent to provide the care and support required. The surveys completed by staff fully reflected the views of people using the service and community professionals and confirmed they received on-going support through training and supervision.

People were assisted by staff who received a thorough and effective induction into their role. All new staff had undertaken induction training which had included the completion of mandatory training. This ensured staff had essential knowledge and information on meeting people's needs. For example, moving and handling people and the use of equipment, safeguarding people, infection control and health and safety. Staff completed a probationary period.

Staff were enrolled to undertake The Care Certificate. This is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. The registered manager and the learning and development manager validated the competence of staff with regards to their theoretical and practical learning.

The staff training programme included training that was tailored to meet the needs of individual people. These specifically focused on people with complex needs, who had a range of areas related to their health and wellbeing that they needed support and care with. Staff had undergone training in areas such as dealing with behaviours that challenge staff, learning disabilities, communicating effectively and end of life care. This enabled staff to conduct their role effectively. A staff member told us how training they had received specific to a person's health had provided them with clearer understanding as to a side effect of a prescribed treatment, which meant the person would frequently cough. Staff told us how they always ensured that drinks were readily available to support the person.

A member of staff told us, how newly appointed staff worked alongside them, initially as an observer. This

provided an opportunity for the staff member to directly see how support was to be provided and gain an insight as to the person's needs. This included understanding how the person communicated as they were non-verbal. The member of staff told us how all aspects of the person's care and support was systematically detailed, so that the member of staff's competence and confidence to undertake tasks could be evaluated.

The induction period also provided an opportunity for people using the service to make any comment or demonstrate their views about the newly appointed member of staff as to their compatibility to support them. A person using the service told us. "I like the way they do the shadowing and training, working alongside experienced staff, gives new staff confidence."

Staff were able to tell us how they applied their training when supporting and caring for people. A staff member told us how their training on autism had enabled them to have a better understanding of why people with autism exhibited specific behaviours and were often driven by the need for sensory stimulation. They told us how they practically applied their knowledge when supporting someone, to ensure they received effective care.

The registered manager had helped to develop a learning environment for staff by appointing champions. Staff were appointed to lead on and be a point of reference for other staff in specialist areas such as safeguarding and dignity. The provider had also joined 'dementia friends' to enable them to keep up to date with good practice.

Records showed that staff received regular supervision sessions. Staff confirmed this while talking with us. Supervision sessions enabled staff to discuss their personal development objectives and goals. We also saw records confirming that staff had received annual appraisals of their individual performance and had an opportunity to review their personal development and progress. A member of staff told us, "I have regular supervisions and received feedback as to my performance; it's always good to be praised for what you do well."

We were told by staff that communication was effective, with support and advice always being available by them contacting the registered manager or care co-ordinator, which included out of hours support. The registered manager and staff referred to an application on their mobile phones, that enabled them to share information effectively and confidentially. Individual groups of staff had been set up using the application on mobile phones to ensure only staff involved in a person's care and support were provided with the information.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA and applications must be made to the Court of Protection. We found there to be no such orders in place.

People only received care with their consent. Everybody spoken with confirmed staff always asked them first before they carried out any care and they had choice in how their care was delivered. One person told us, "They always ask my consent, but do suggest options for me if they think there is a better way of doing things but they are not pushy, but helpful." Staff were clear about the rights of the people they supported.

The registered manager and staff aware of the MCA and informed us that people who received support were able to make decisions about their care or had family members who represented them, which included where people had Power of Attorney in decision making. People's records reflected the decisions they had made about their care and support. For example; where they had declined aspects of personal care or had chosen not to have a meal. A member of staff told us how in some instances they made a best interest decision when a person they supported embarked on an activity to excess, which increased their risk of having a seizure. In these circumstances staff said they distracted the person, by taking them out for a drive in the car. This is an example of staff making a best interest decision for a person, when they do not have the mental capacity to make an informed decision.

Assessments were undertaken to assess any risks to people who used the service with regards to their nutritional intake, which included the risk of people not eating or drinking enough. Care plans provided guidance for staff on how to reduce the risk and promote people's health and welfare. For example, by ensuring staff prepared and cooked meals for people and encouraged them to eat and drink, with people's care plans directing staff to ensure people had a drink and snack left close to them which they could reach. To encourage people to eat, people's views about their meal preferences had been sought and recorded, for example where people were vegetarian or required a soft diet to prevent the choking.

Staff supported people in the promotion of their health and welfare and its impact on their lives. For example a person experienced being breathlessness. This impacted on their ability to actively take part in their personal care. Their care plan instructed staff not to use aerosol sprays, such as cleaning products and deodorants as this had affected the quality of their breathing. People's care plans reflected the role of staff in supporting people to manage health care conditions, which included epilepsy and diabetes. People's care plans detailed the action required by staff should they have concerns about people's health and welfare. For example, the signs a person's catheter maybe blocked or the signs and symptoms a person may show if their diabetes was not being controlled well. Staff liaised with health care professionals involved in people's care, where they had concerns. For example, district nurses who administered people's insulin and where staff identified concerns with people's catheters. This showed staff were aware of their role and responsibilities and took action by contacting health care professionals appropriately.

The evidence we found supported the information submitted by the registered manager within the PIR.

Good

Is the service caring?

Our findings

People were supported by a core group of staff, which enabled positive and caring relationships based on knowledge and trust to be developed. A person we spoke with told us staff were, "Very friendly." They went onto say. "The girls [staff] are like an extended family, they bring life to me." Staff were introduced to people who used the service before they provided their care and support. That ensured people using the service were confident in the members of staff had abilities and confidence in them to meet their needs. A person shared an example of how they hadn't made a connection with a member of staff and they had fed this back. The registered manager had taken action by changing the staff involved in the person's care. The registered manager informed us that in some circumstances, where people had complex needs staff were recruited specifically to work with that individual. Consideration was given to the potential staff member's personality, hobbies and interests as a way of helping to determine whether they could support a person well reflective of their needs.

People's comments within the CQC surveys that were returned reflected fully that people were introduced to staff before they provided their care and support and that they were happy with the service they received. This was confirmed in a majority of the surveys completed by staff.

The registered manager demonstrated a very strong and visible person centred culture by providing a service which put people at the heart of everything they did. Staff were knowledgeable about people's specific needs and how to support them in making decisions about their care and support. For example one member of staff shared their experience of supporting a person with a learning disability who was on the autistic spectrum. They said, "I observe the body language of [person's name]. This enables me to anticipate potential situations and interpret what they are trying to communicate." For example, "Due to their autism they have to complete tasks a certain way, if we were to interrupt this then their behaviour could be challenging." The member of staff went onto to tell us about positive behaviour support (PBS). They told us how this approach was used to reinforce positive behaviour, and where negative behaviour was displayed; the idea was to intervene to turn the negative behaviour into something positive. Staff were aware of the necessary actions to take to stop negative behaviour before it appeared. The person's care plan we read identified this approach. It identified the need for staff to be consistent in their approach to the person's behaviours and not to make sudden changes but to be predicable and structured, as agreed with the person's family representative.

People's care records confirmed that staff had taken time to gather the outcomes and goals that people wanted to achieve, for example a person's care plan regarding their care around their medical condition stated 'I would like my skin integrity controlled, looked after and my concerns reported. I would like all staff to follow prescribed medicine instructions to ensure that my skin integrity does not deteriorate.' We spoke with the person who told us they had been very much involved in the development and on-going revision of their care plans; they said "I feel as though I am consulted on a daily basis about my care."

People's comments within the CQC surveys that were returned reflected staff fully respected people's privacy and dignity, which was also reflected within surveys that were completed by community

professionals and staff.

People's diversity was respected as part of the strong culture of individualised care. Care plans and behaviour support programmes gave detailed descriptions of people. Each person was provided with activities, food and a lifestyle that respected and suited their choices and preferences. The care plans included each person's history, their religion, what they preferred and enjoyed and how they expressed themselves. For example, one person enjoyed going on their trampoline and spending time in their play room.

People in receipt of end of life care and their family members were involved in the development and reviewing of their care. A person's records showed a meeting to discuss a person's needs was held which was attended by health and social care professionals.

Staff were aware of their responsibilities which related to confidentiality and preserved people's personal information. Staff understood their legal duty to protect personal information they encountered during the course of their work. Staff understood the importance of respecting private information and only disclosed it to people such as health and social care professionals on a need-to-know basis and with people's consent. The registered manager had provided training to staff on information governance, which included how information was to be recorded and stored.

The provider had in place a 'service agreement', which provided information as to how data held about people was stored and used, to assure people that information was held in accordance with the data protection act. People's records we looked at contained a 'service agreement', which had been signed by the person or their representative, which included information on data protection.

The evidence we found supported the information submitted by the registered manager within the PIR.

Good

Is the service responsive?

Our findings

People had an initial assessment of their needs in some instances these were carried out by a social worker where their care package was funded. The registered manager told us, "When we receive a referral we ask ourselves, are we going to be able to make a difference to someone's life before we accept them." There comment was based on the services vision and values of improving people's quality of life. The registered manager then undertook an assessment of people's needs by visiting them within their own home or their current place of residence, to ensure the service could provide the support and care they required.

People's comments within the CQC surveys that were returned reflected fully that people were involved in decision making about their care and support and if requested the service would involve people important to them, such as family members. Community professionals confirmed that staff from the service responded to any advice they gave and worked collaboratively with other services involved in people's care, for example when a person's needs changed.

Assessments were used to develop care plans, which were person centred, 'Person centred' is a way of working which focuses the actions of staff on the outcomes and well-being of the person receiving the service. A personalised care plan was provided to each person so they understood what had been agreed and arranged. Care plans detailed how staff made sure people were appropriately cared for and we looked at how this was documented. For example, by encouraging and supporting people to access the wider community.

Care plans were regularly reviewed; the frequency of review being dependent upon the needs of people. Where people's needs had changed, commissioners funding people's care were informed. Records showed how people's care plans had been updated to reflect people's changing needs. For example, the number of staff involved in supporting a person with their personal care had reduced due to the introduction of equipment.

People's care plans provided were very individualised and reflected the support and care people needed, enabling staff to provide person centred care. For example, a person's care plan detailed the support they needed to maintain a comfortable environment in which they lived. It stated how the central heating temperature control worked and the action staff needed to take in operating this. The care plan identified how staff were not to use aerosols, in the vicinity of the person as this had the potential to have a negative impact on their health care condition.

A further example of a very individualised and person centred support plan had been put into place to support a person who lived within a family home with the introduction of a new family member to the household. This was to ensure the person continued to feel supported and not excluded. The person's plan detailed comprehensively how staff were to support the person, and how they were to be introduced and supported in getting to know the new family member. The care plan included 'trigger' words the members of the family should use where they thought the person using the service would not respond well to the new family member, so that action could be taken to ensure the safety and welfare of all.

The person we spoke with could not recall having made an official complaint but stated that they would be happy to do so if necessary; they told us they had made comments which had been actioned by the registered manager, which included a change to staff who delivered their care.

People's comments within the CQC surveys that were returned reflected fully that people knew how to make a complaint and that the service, and staff responded well to concerns or complaints they raised. This was confirmed by the surveys completed by community professionals and staff.

The provider had a complaints policy and procedure which detailed how people's concerns and complaints would be managed, including the timescales involved. In addition the policy and procedure included contact details for external organisations, which included the local authority and Local Government Ombudsman (LGO).

The most recent complaint received by the provider was in July 2016. This had been investigated to the satisfaction of the complainant who had received feedback on their concerns. We looked at the records and found all concerns were recorded, investigations and the outcome including any lessons learnt were noted. We saw records which evidenced the action taken. For example where medication had not been administered as required, in addition to a safeguarding referral being made to the local authority, the registered manager had revised the policy and procedure for the management of medicine. The MAR's were reviewed making it clearer for staff to follow and complete. Additional training was provided to all staff and individuals involved in the incident were supported through supervision and spot checks to ensure improved practice had been attained.

The evidence we found supported the information submitted by the registered manager within the PIR.

Good

Is the service well-led?

Our findings

People were empowered to have a say about the running of the service. Feedback was recognised as an essential part of quality assurance through visits and phone calls. They took place at different times during people's experience of the service. Spot checks on staff practice also provided an opportunity for people to talk with managerial staff about their experience of care.

Surveys included space to record any action taken by the registered manager, which included where a visit to a person's home was required to discuss the issues raised within the survey. We saw examples of where the care co-ordinator had visited people to discuss issues, such as time keeping. This was confirmed by the person we spoke with, who told us it was an effective way of monitoring the service.

People's comments within the CQC surveys that were returned reflected fully that people knew how to contact the service and that their views about the quality of the service were sought. They stated information provided by the service was clear and easy to understand. Staff comments within CQC surveys fully reflected that the registered manager took into account their views and that they had access to important information as soon as they needed it. Surveys completed by community professionals recorded that the service was managed well and continuously strived to improve the quality of care and support they provided for people.

People using the service had a keyworker, who on a monthly basis produced a report focusing on the person's current well-being, which included noting any changes to the person's health or welfare. This acted as an indicator as to whether there was any deterioration in the health of a person. The keyworker presented this report at the monthly staff meeting and was used as an introduction for staff involved in the person's care to evaluate the person's care and discuss any specific points which may require further attention. Team meetings were used an opportunity for the registered manager to update staff on key policy and procedure changes, and staff training.

The registered manager supported staff in a range of ways, which included, a staff handbook which included key policies and procedures. Staff had on-going training, supervision, assessments of competency to perform their work, team meetings and the line management structure which provided an on-call service for staff to access out of office hours. Staff spoke positively about the support they received.

Direct Care – Leicester was run by the registered manager, who was also the provider [nominated individual]. High quality and individualised training and a strong support system for staff was key to staff retention and job satisfaction. For example, a staff member said the training was "Very good and comprehensive" and another stated, "Training is always available, it's on-going. I find it interactive and helpful." Regular team meetings with minutes aimed to help staff keep up to date with best practice. Training was linked with national organisations such as Skills for Care. There were systems in place to monitor staff performance through spot checks as well as formal supervision and annual reviews.

The registered manager told us of their plan for future was to appoint a manager, who would apply to CQC

to be registered. At which point the current registered manager would resign their role as registered manager, and to continue in the role of provider. They told us this would enable them to have a more strategic overview, setting clear key performance indicators for staff and to focus on quality assurance. They told us their commitment was to ensure both people using the service and staff were happy.

Staff told us how they could visit the office informally at any time for advice and support and also attended meetings and sessions to discuss their own personal and professional development. One staff member told us, "They [the registered manager] are always available by telephone or through an application on their mobile telephone." Staff knew about the whistle blowing policy and procedure and said they would be confident to use it if necessary. The whistle blowing policy enabled staff to feel that they can share concerns formally about poor or abusive practice without fear of reprisal.

Community professionals had within the surveys sent out by CQC included additional comments about the day to day management of the service. For example. 'I have always found this agency to be thorough and cautious in comparison to other care agencies. The managers' take their time to raise concerns in a timely manner and have also worked with me to resolve any issues.' Feedback from service users has always been positive, including those service use who are challenging.' And added, 'From what I have seen it [service] seems to be safe, caring and effective. ……The manager is keen to involve health care professionals in the care offered and follows recommendations given.'

A member of staff had commented within their returned CQC survey 'I feel valued and respected as a member of staff working at Direct Care, but most importantly I feel that our clients are happy and safe as all the clients I work with give positive feedback about the care they receive, company and staff.

There was strong leadership with a clear set of values which ran through the service. The people using the service and staff were equally valued. There was a commitment to providing high quality care and an energy to help the service improve and develop to match the changing needs within adult social care.

The provider had attained the ISO 18001, this sets outs minimum requirements for occupational health and safety and management best practice, and evidences a commitment to maintain and improve how the service manages health and safety. The provider had also attained the ISO 9001 Certification and UKAS accreditation, this evidences the provider is working within the guideline of a quality management system. This means an external contractor periodically visits the service to review a range of documentation and processes to ensure the quality assurance system is effective and makes any recommendations for the provider to action. We saw reports from their visits, which fully documented the records viewed and any action recommended, which were documented by the provider as being actioned. For example, improvements were made to the destruction of confidential waste by ensuring it was immediately shredded.