Jay's Homecare Limited

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Inspection report

Unit 22
The Wenta Business Centre, 1 Electric Avenue
Enfield
Middlesex
EN3 7XU

Tel: 02083647797

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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 15 and 16 December 2016. We gave the provider 48 hours' notice that we would visiting their office as we wanted to make sure that the registered manager would be available on the days of our inspection. The service was last inspected on 04 August 2014 and was meeting all the regulations that we looked at.

Jays Homecare Ltd provides domiciliary care services to 85 people living in their own home. The service works with people living with dementia, learning disabilities, older people and people with sensory, physical and mental impairments.

There was a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run.

People told us that where staff supported them with their medicines, this was carried out appropriately. We looked at seven Medicine Administration Records (MAR) and found that there were no gaps in recording. MAR charts are the formal record of administration of medicine within the care setting. However, where medicines were administered from a blister pack or dossette box, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart.

Individualised care plans were available and written from the point of view of the people that were being supported. Care plans were detailed and provided information to enable staff to support people appropriately. We saw that care plans were regularly reviewed and updated as changes occurred.

Risk assessments were personalised and identified risks associated with people's care and support needs. Where risks were identified, there was detailed guidance available for staff to ensure that identified risks were managed or mitigated so that people were kept safe from harm.

People told us that they felt safe with the staff that supported them. Staff were able to explain how they would recognise and report abuse and clearly understood their responsibilities in keeping people safe.

The service followed robust recruitment procedures to make sure that only suitable staff were employed.

Complaints were appropriately investigated and details of the actions taken were clearly noted with a response sent to the complainant acknowledging their concerns and the actions taken to make improvements where necessary. However, we noted that the complaints received all detailed a common theme in relation to lateness of staff, missed visits and poor communication.

People and relatives told us that they received a team of regular care workers to support them. The service

tried to ensure that the same care staff were allocated to a person's care package. Although people confirmed that this generally happened, where a change was required due to regular care staff being on annual leave or on sick leave, changes were not communicated effectively by the office staff.
Staff confirmed that they received regular training and supervision in order to support people effectively.

Staff understood that it was not right to make decisions and choices for people when they could make decisions and choices for themselves. People's ability around decision making, preferences and choices were recorded in their care plan and followed by staff.

People and relatives confirmed that they were involved as much as they wanted to be in the planning of their care and support. Support plans included the views of people using the service and their relatives.

A number of quality assurance systems were in place which included spot checks, quality assurance reviews and quality surveys and questionnaires. Where areas for improvement were identified, the information was used as an opportunity to improve the care and support people received.

Staff attended regular team meetings and completed annual surveys where they were able to give their views and feedback about the quality of the service that they delivered. Staff confirmed that any ideas or suggestions that they had were listened to and where possible improvements were made.

Most people and relatives knew the registered manager and office staff and were positive about how the service was managed overall. Care staff were also complimentary about the director as well as the registered manager and felt able to approach them with their concerns.

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 supported to have their medicines safely. However, where medicines were administered from a blister pack or dossette box, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart.

People told us they felt safe and trusted the staff who supported them.

Risks for people who used the service were identified and comprehensive risk assessments were in place to ensure known risks were mitigated against.

There were sufficient staff to ensure that people's needs were met. There were robust recruitment procedures in place.

Is the service effective?

Good

The service was effective. Staff received regular training and supervision to enable them to carry out their role effectively. People were positive about the staff and felt they had the skills and knowledge necessary to support them appropriately.

Staff understood the principles of the Mental Capacity Act 2005 (MCA) and how this should be reflected in the care and support people received.

People's healthcare needs were monitored and referrals were made where required to ensure well-being.

People's food and dietary preferences were noted in their care plans.

Is the service caring?

Good

The service was caring. People told us that staff treated them with compassion and kindness. Staff were able to describe people's likes and dislikes and demonstrated a good awareness of their life history.

People were treated with respect and staff maintained privacy

and dignity.

People were supported to make informed decisions about the care that they received.

Staff understood that people's diversity was important and something that needed to be upheld and valued.

Is the service responsive?

Good

The service was responsive. The care people received was person centred and planned in response to their needs and wishes.

Staff were knowledgeable about individual support needs, their interests and preferences.

Complaints were responded to in an effective and timely manner. However, we noted that the complaints received detailed a common theme in relation to lateness of staff, missed visits and poor communication.

Is the service well-led?

Good

The service was well-led. People and their relatives knew who to speak with to discuss their care and support needs. This was not always the registered manager, but was more regularly the care co-ordinators or field care supervisors.

Audits and surveys were undertaken to assess and improve the standard of care.

Regular quality reviews were completed in addition to annual quality surveys that people and relatives were asked to complete. Where concerns were raised or patterns identified from surveys then this was discussed with people when carrying out individual quality review meetings and when people raised concerns, this was addressed on a case by case basis.

Jays Homecare Limited

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 15 and 16 December 2016 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 the registered manager would be available to support us with the inspection process. The inspection visit was carried out by one inspector on the first day of the inspection and two inspectors on the second day of the inspection. In addition, on the second day of the inspection, two experts by experience carried out telephone interviews with people and relatives who used the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with 10 people using the service and five relatives.

On 16 December 2016, with prior consent, we undertook visits to people's own homes to speak with them about the service that they received. As part of this visit we also looked at records that were held in people's own homes. We visited three people in their own home where we were able to speak with two people and one relative.

Before the inspection we looked at information we had about the provider which included notifications of any safeguarding or other incidents affecting the safety and wellbeing of people. Prior to the inspection we also wrote to a number of professionals which included local authority commissioners for their feedback about the provider.

During the inspection we spoke with the registered manager, one field care supervisor, one care co-ordinator and six care staff members. We also looked at a variety of documents which included ten people's care plans, risk assessments, five staff files, meeting minutes, quality audits and surveys and a number of policy documents.

Good

Is the service safe?

Our findings

People and their relatives told us that they felt safe and were happy with the care staff that supported them. One person said, "I feel every bit safe. They [care staff] understand that they can't leave things on the floor as I am blind and that they can't move things from here to there. They use their initiative." Another person told us, "Yes I feel safe with my carer, I'm confident with her when I have a shower. She does help me, I don't feel awkward with her, and I'm relaxed with her. She watches me." One relative commented, "[Name of person] does feel safe. [Name of care staff] is a friend to him." Another relative stated, "Yes my father is safe." A third relative stated, "Yes I have no reason to not think she [Relative] doesn't feel safe."

We looked at Medicine Administration Records (MAR) for five people. MAR charts are the formal record of administration of medicine within the care setting. Care staff recorded appropriately when medicines were administered and were required to regularly bring to the office completed MAR's which were audited and checked so that managers could identify any issues with recording or gaps in recording. Where gaps were identified the service was able to explain the reason for the gap. However, this was not formally recorded by the service and a note was not made on the MAR which would easily explain the reason for the gap.

In addition, where medicines were administered from a blister pack or dossette box, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. The MAR referred to 'Dossette Box.' We did note that the service had recorded people's prescribed medicines on their care plan and this was updated if and when changes were communicated to the service. We did bring this to the attention of the registered manager who explained that this method of recording was as per the provider's policy. Care staff were only allowed to administer medicines from a dossette box pre-filled by a pharmacist which listed details of the different medicines contained within the box, the dosage and the times the medicines were to be administered. Care staff were aware that if any of this information was missing from the dossette box then the medicine was not to be administered. Care staff that we spoke with confirmed this.

Medicine administration risk assessments were completed so that the level of need and support could be identified and staff were provided with the appropriate guidance on how to safely support people with their medicines.

Staff told us and we saw evidence that care staff received medicine training on a yearly basis. Each staff member, on completion of their medicine training were required to complete a competency assessment to give assurance that staff demonstrated the appropriate level of knowledge to safely administer medicines. Records seen confirmed this.

We recommend that the provider ensures that they are following NICE medicine administration guidelines which clearly outlines the requirements placed on domiciliary care agencies to ensure the safe administration of medicines.

Staff could explain how they would recognise and report abuse. They told us and records confirmed that

they had received training in safeguarding adults. One staff member told us, "I would report any concerns to my supervisor at all times." Another staff member stated, "I would first report to the office and they would tell me what to do." A third staff member explained, "I would see if my client was okay and then I would record and report it to my manager." Staff understood how to whistle-blow and were confident that the management would take action if they had any concerns. Staff were aware that they could also report any concerns to outside organisations such as the police, local authority or the Care Quality Commission (CQC). One staff member told us, "When you see something has happened, you can call the office or you can call 999 or the community alarm."

Risk assessments were undertaken to identify risks associated with people's care, support and health needs. Assessments also provided guidance for staff on how to reduce or mitigate risks in order to keep people safe. Areas that were assessed included mobility, moving and handling, falls and medicine administration. For people who were assessed with behaviours that challenged the service, risk assessments were completed on how to mitigate risks, which included the steps to be taken to de-escalate situations such as holding a conversation with a person. We noted that the assessment did not include the type of conversation staff should hold with the person, such as their topic of interest. The registered manager told us that the person enjoyed general conversations and staff did not need to hold specific conversation.

Falls risk assessments had been completed for people at risk of falls. The risk assessment listed information on how to mitigate the risk of falls, the reason why a person is at risk and also, where required, listed items such as walking aids to be used. One person's risk assessment detailed that the person had swollen ankles and therefore staff to ensure the person did not walk long distances without support. Another care plan detailed the person was unsteady when standing up therefore staff should ensure the person was supervised at all times especially when trying to stand up.

Assessments were also completed related to people's health conditions to minimise the risks of serious health complication. For people diagnosed with diabetes, risk assessments provided guidance to staff on what to do if there was an incident of where a person's blood sugar level was to drop, which is known as hypoglycaemia.

Environmental risk assessment had been completed to ensure the safety of people and staff. These covered risks associated with lighting, fire and clutter. In one risk assessment we saw that a smoke alarm had not been fitted on a person's home. The staff member completing the assessment advised the person about the importance of having a smoke alarm and contacted the London Fire Brigade to install the smoke alarm with the person's consent.

Staff files demonstrated that the provider followed safe recruitment practices. We looked at five staff recruitment records. Records showed the provider collected two references from previous employers, proof of identity, criminal record checks and information about the experience and skills of the individual. Gaps on employments were explored with staff and recorded on a separate document.

Care staff did not raise any concerns about staffing levels and told us that they were allocated sufficient time to travel between each allocated call as well as enough time to carry out the tasks required as part of a person's care and support plan. We looked at the rota system in place which informed staff of the shifts they were allocated and found that shifts were booked with no travel time allocated in between. We highlighted this to the registered manager who explained that the rotas were an administration process and was not a true reflection of the shift allocations.

Most people and relatives that we spoke with confirmed that they were allocated regular care staff which

enabled people to experience continuity of care. People told us, "Yes he [carer] comes on time and is very good. He does everything I ask him to." Another person said, "I usually have the same carer, they don't let me know if they are coming late." A relative commented, "I have the same carer every day, [Name of carer]. She is good but her timing is not good, she doesn't let us know if she is coming late."

Complaints records that we looked at also recorded concerns which had been raised, about staff not arriving on time and occasional missed visits and poor communication from the office to inform them of the lateness or change. Based on this information we again brought this to the attention of the registered manager. We had already identified that the rotas did not evidence that sufficient travel time was allocated to staff, although staff did confirm that they were allocated time to travel. The registered manager assured us that they would look at their systems to ensure that people received their care in a timely manner and effective communication was maintained to improve services that people received.

No accidents and incidents recorded. We looked at the accident and incident policy, which detailed how accidents are caused, how to investigate and how to complete the accident and incident form.

All care staff had full access to personal protective equipment (PPE). We observed that care staff were able to come to the office and collect the equipment that they required.

Good

Is the service effective?

Our findings

People who used the service and their relatives told us that they had confidence in the staff who supported them. People's comments included, "They know what to do, they are skilled and trained," "Yes they are well trained to look after me. I feel confident that they are doing their job well; I think we are a team. They are good they know what they are doing" and "Yes she has been trained brilliantly she does everything to the book."

Records showed that staff had completed induction training and this covered health and safety, infection control, communication, moving and handling, safeguarding's, Mental Capacity Act 2005 (MCA), food hygiene and risk assessments. When staff had completed their induction, competency assessments were carried out on communication, medicines, moving and handling, health and safety and safeguarding's to check staff understanding on these areas.

Staff told us and records confirmed that staff had undertaken mandatory training, which included first aid, medicines, moving and handling, health and safety, safeguarding's, communication and the Mental Capacity Act 2005 (MCA). Staff had also undertaken training in specialist areas such as dementia, pressure sore management, diabetes, continence, eye drops, warfarin administration and managing challenging behaviour. Records showed that staff also had completed the Care Certificate, which is a set of standards that social care and health workers adhere to in their daily working life. The service had systems in place to keep track of which training staff had completed and future training needs. We saw letters had been sent to staff that listed refresher training staff would need to complete. The registered manager told us, "Good training is the key to success."

Care staff told us that they felt supported in their role. They felt able to request additional training where required and received regular supervision. One staff member told us, "We can call and they will always answer. Supervisions are really helpful, they ask about how we are feeling." Another staff members said, "Being able to call someone when you need help. They [management] are accessible and they lead you on what to do, this is what I like."

The service maintained a system of appraisals and supervision. Individual one-to-one supervisions were provided and at these supervisions staff were able to receive feedback about their performance and also discuss any concerns and training needs. Appraisals were scheduled annually and we saw that staff had received their annual appraisal in 2016.

Records showed that spot checks were being carried out and the results were communicated to staff. The spot checks covered areas on time-keeping, personal care, moving and handling and communication.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do 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 the best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. Records showed that all staff had received MCA/DoLS training. The registered manager, members of the management team and all care staff had a good understanding of the MCA and how this impacted on the care and support that people received. One staff member told us, "Our clients have the right to make their own decisions and we have to protect those rights. For example if someone has dementia we have to look at the processes in place to protect them." Another staff member said, "It's about a person who is able to make decisions and take decisions about their care." A third staff member explained, "I always seek consent from people. You don't judge a person just because they lack the ability to make decisions for themselves."

People's care files contained a consent form which was signed by the person using the service or where the person was unable to sign the consent form was signed by a relative or next of kin. People told us staff always obtained consent whilst they were being supported. One person told us, "They do ask my permission but they also know what they have to do." Another person said, "They ask me before they lift me and tell me what they are doing."

One person's care plan stated that the person was living with dementia and it had been assessed that the person lacked capacity. However, the positive manner in which the care plan had been written, ensured that the person was supported to maintain their independence where possible and that the care staff were only to prompt and encourage where necessary. One entry stated, "[Name of person] wants to stay as independent as he is now. He does most things by himself and only requires the carers to prompt him due to his poor memory."

There was information incorporated into people's support plans about their likes, dislikes and preferences in relation to food and drink. Where appropriate and when this was part of a person's care package, details of their dietary needs and support required was recorded which also included any requirements as a result of a cultural or religious need.

Where people received support with eating and drinking, people told us that they were happy in the way they were supported. One person told us, "Yes they help with meals, they heat it up. I have food which I have bought and they will heat it up in the microwave." Another person said, "They help me with my breakfast and lunch. My husband leaves the meals for lunch and the carer heats it up for me. For breakfast I have cereal or porridge."

Where the service took responsibility for organising and accompanying people to healthcare visits and appointment, the details and outcomes of those visits had been recorded within the person's daily record notes. Support plans included detailed information about the person's healthcare needs and provided guidance to staff how about to support people to manage the specific conditions. Staff we spoke with had a good understanding about the current medical health conditions of the people they supported. They knew who to contact if they had any concerns about a person's health including emergency contacts.

Good

Is the service caring?

Our findings

People and relatives told us that they thought the service was caring and that they were treated with respect and compassion. One person told us, "Yes she [carer] is polite and kind, she [carer] is doing everything I need to do, she [carer] will help drop off the prescription if I need to. She [carer] does the shopping too, she [carer] is okay." Another person explained, "They are good they know what they are doing. I'm happy with them and they look after me.' They have been with me through thick and thin." A third person said, "My carer is a good man, he is respectful and very good. He does what he can, he does his best. He does my cleaning, he does his job properly. He never offends me at all. He never says no, he does my shopping too."

Relatives comments included, "She is cheerful and polite, is very good. The previous carer was able to tidy up and wipe the floor, the new carer doesn't do these things. I would like her to but haven't asked her about this, I could ask her I suppose," "The carers are okay, they care" and "Yes the carers are nice, very pleasant, always ask if we need anything."

People and relatives told us that they received care and support from a regular team of carers and had established a caring relationship with them. One person told us, "Yes, she is just like a family to me very loving and willing, a nice person." Another person said, "Yes, she [carer] would come in and say good morning, how you feeling and how's the pain. She's very motherly very comforting."

Staff that we spoke with also knew people well and were able to tell us about people's likes and dislikes, preferences as well as their life histories. One staff member said, "I take particular interest in what health difficulties a person has so that I have an understanding of how to support them." Another staff member told us, "I was supporting a person for the last 13 years who recently passed away. My clients treat me as their family."

Care plans were person centred and were aimed at ensuring people maintained as much independence as possible. Care plans noted what people were able to do by themselves and they needed help with. People and their relatives told us that they were involved in developing their care plans and identifying the support they required from the service and how this was to be carried out. One person told us, "Yes I have a care plan, I am speaking with the office about my care plan and the carers to do what they should be doing."

Care plans also included background information, such as people's ethnic background, religious beliefs and dietary requirements. Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender and supported them in a caring way. One care staff member said, "You have to understand people's backgrounds. Whether that be cultural or sexual. We should treat everyone as equal." Another staff member explained, "We have to respect people's beliefs and wishes. I have to respect their rights to do what they want and not to try and impose my wishes and beliefs on them."

People and relatives confirmed that they were treated with respect and their privacy was maintained. One person said, "Carers are very caring and very respectful." One relative said, "Carers all seem quite caring and respectful." Staff gave us examples of how they maintained people's privacy and dignity not just in relation

to personal care but also in relation to sharing personal information. Staff understood that personal information about people should not be shared with others and that maintaining people's privacy when giving personal care was vital in protecting people's dignity. One staff member told us, "I would not disclose people's information with anyone." Another staff member said, "When giving personal care don't expose people, always cover them up. Protect them. Put yourself in their position would you be okay if someone put their hands all over you."

Good

Is the service responsive?

Our findings

People using this service and their relatives told us that the management and staff responded to any changes in their needs. One person told us, "The carers always stay their time and sometimes extra if I have a problem. Sometimes if I am waiting for the nurse or I am in distress, the carers would wait behind or they would call my son or the nurse." One relative told us, "[Name of the person] can be reluctant to accept care but the carers to talk him around."

We looked at care plans for 10 people. These contained a pre-admission document which showed that people's needs had been assessed before they decided to use the service. People confirmed that someone from the service had visited them to carry out an assessment of their needs. These assessments had ensures that the service only supported people whose care needs could be met. The registered manager told us that if someone's assessed needs were too complex a service would not be offered.

All care plans had a profile outlining the person's health conditions and support needs. There was a personal history section for each person providing information on people's background and also included what people enjoyed doing and key memories they held that was significant to them. These plans provided staff with information so they could respond to people positively and in accordance with their needs.

People's care plans were personalised and person centred to their needs and preferences. Care plans clearly listed the support and care people would need and the times staff should attend. People's support plans were divided into areas which included nutrition, mobility, physical well-being, allergies and social emotional needs. One person's care plan detailed that a person had bandages on their legs due to sores and staff to take care when washing the person's feet. Another person's care plan detailed a person liked to walk and provided information for staff to take the person out for walks. This meant the care plans were not general and were personalised to people's preferences and needs.

People's ability to communicate were recorded on care plans for staff to understand how people communicated and the methods they used. One example included a person who was unable to hold a conversation due to dementia. Instructions were provided to staff on how they were to speak with the person using short sentences and to use their body language to express themselves to the person.

Reviews were undertaken regularly with people, which included important details such as people's current circumstances and if there were any issues that needed addressing. There was a review's chronology section that listed what had been updated in the care plan following the reviews. People and relatives confirmed that someone had visited or called them to review the service that they received. One person told us, "They do call to check how things are going." Another person said, "They do check and do reviews."

Daily log sheets were available at people's home, which recorded key information about people's daily routines such as behaviours and the support provided by staff. In one entry we noted that there was no hot water at a person's home and staff had called a contractor to repair this. All daily record notes were brought into the office at the end of each month and these were checked by the field care supervisors to ensure that

the records were being completed appropriately.

We saw an area of best practise where the agency intervened to request additional support a person received. Contact was made with the local authority setting out reasons why further support was needed. Although challenges were made by family members, following assessments made by social professionals, this request was granted to ensure the person maintained good health through regular support and care.

People confirmed they were offered choice in how they received their care. Staff demonstrated a good understanding of person centred care and how to promote people's independence by involving them and giving them choice and control over the care that they received. Care staff gave us different examples of person centred care, how they promoted independence and gave people choice. One staff member told us, "We look at their capabilities, focussing on what they can do and not what they cant. It's about looking at them as an individual and you have to understand that the little that they can do for themselves – not to take that away from them." Another staff member explained, "People want to be treated in their way and will tell you what they want. If people can make their own cup of coffee then support them. If you support them they feel more independent." A third staff member stated, "We are not there to take away their rights but to encourage them to do the things that they can still do."

Most people and relatives we spoke with confirmed that they had no complaints about the service. They also stated that they felt able to raise any concerns and knew who they needed to speak with to do this. One person told us, "My daughter would call the office if I had any concerns." Another person said, "I would call [Name of field care supervisor] of one of the people at Jay's and they would address the concerns immediately. One person that we spoke had encountered a slightly negative experience and told us, "I did make a complaint a while ago. I didn't feel safe with the carer, I slipped in the shower and she was there just watching me. I told the office not to send her again but they did. I refused to open the door to her. The agency said they didn't have anyone else to send. I felt that they didn't listen to me, but they did find me a carer."

We saw from detailed records that complaints received had been investigated by the registered manager and had been resolved appropriately. The registered manager also ensured that they initially acknowledged the complaint and provided regular updates on their investigation with the actions they had taken to improve the service. However, we noted that all complaints received detailed a common theme in relation to lateness of staff, missed visits and poor communication. The registered manager explained that sometimes monitoring lateness and missed visits proved difficult especially where care staff would not effectively communicate with the office so that they could inform the person that the carer was running late. In addition, people or relatives would also not call the office to inform them were a staff member had not arrived for their call. The registered manager stated that effective communication was an ongoing issue which they were trying to address, however, the registered manager told us that they would further look at their systems and processes to ensure these issues were resolved so that people received an improved service.

Good

Is the service well-led?

Our findings

People and relatives were overall positive with the service they received and positively commented about the way in which the service was managed. One person told us, "They do an excellent job, I'm happy with them and they look after me." Another person said, "I'm fine with the service, I would call the office if I had a problem." A third person stated, "The service is okay, they need to train their staff more. Some of them don't know what they are doing. My carer at present is okay." Relative's comments included, "The service is okay, I could call the office if I needed to but not had to really. The issue of timekeeping is minor" and "I'm happy with the service."

Mostly all people and relatives that we spoke with knew who the registered manager was and felt able to contact them if there were any issues or concerns. However, there were some people who did not know who the registered manager was but did know that they could contact the office any time and speak with the field care supervisors or care co-ordinator to discuss their concerns. One person told us, "I don't know the manager but I can call the office." Another person said, "I don't remember the name, I've not met them." One relative said, "I don't the manager but I know who to call. Don't worry if I was put out I'd be on the phone."

Staff told us that they enjoyed working with the service. Some staff that we spoke with had been working with Jay's Homecare Limited for over 10 years. Staff told us that they were encouraged and empowered to make suggestions for improvements and that the registered manager and senior management team took note of the suggestions and implemented them where possible. The registered manager and staff members told us that there were good opportunities for career development and a number of staff including the registered manager confirmed that they had been promoted within the organisation. The registered manager told us, "The company invests in its staff. I started as a project manager and then became the registered manager and was then promoted to company director. All care staff are encouraged to develop." One field care supervisor told me about how they were promoted from being employed as a carer to becoming a field care supervisor and said, "They [provider] are very keen on moving forward and developing."

Staff told us that they felt supported in their role and that the registered manager and all office staff were approachable at all times. One staff member said, "[Name of registered manager] is fine, approachable. A very strong woman who demonstrates leadership." Another staff member told us, "[Name of registered manager] is lovely, approachable and understanding. I love this job."

Staff told us and records confirmed that regular team meetings were held. Agenda items for discussion included, training, safeguarding, time management, lateness and cancellation of shifts, no reply when arriving at a person's home, record keeping and medicines management. Records confirmed that lateness, missed visits and effective communication was a standard agenda item at every meeting which assured us that the provider and the registered manager had identified and were trying to address the complaints and issues recorded around lateness, missed visits and people not being contacted to inform them of any changes.

The service regularly held quality assurance meetings with people individually about the service and about the staff who provided personal care to them. Feedback and actions were followed up with staff. Comments from people included, "Me and my family are really happy with [staff member], he is very hard working and always happy" and "All in all, I couldn't ask for a better person looking after me than [staff member]. She does everything and her personal care is very good."

The service had a quality monitoring system which included questionnaires for people who received personal care from the service. We saw the results of the recent questionnaires, which included questions around staffing, punctuality, respect, personal care, communication and staff knowledge. The overall feedback was positive. Comments from the survey included, "I am happy with service". The results of the survey were analysed. We found that some people suggested areas of improvement that could be made regarding communication. Comments from people included, "I would like to be rang if a carer will not be calling [attending] or going to be late" and "If a carer is going to be late or miss a visit to communicate with me."

We asked the registered manager if an action plan was in place to address these concerns. The registered manager told us that an action plan had not been created but where concerns were raised or patterns identified from surveys then this was discussed with people when carrying out individual quality assurance meetings and when people raised concerns, these were addressed on a case by case basis.

The registered manager was also required to complete quarterly management reports which listed an overview of late visits, missed visits, complaints, accidents and incidents and compliments. Where issues were identified details of the actions taken were noted on the report to ensure that learning and improvement took place.

The service also had a variety of other quality monitoring systems, which included questionnaires for staff, checks of MAR's and daily recording notes and an overview of when people's reviews, supervisions and appraisals were due. The provider used an electronic rota system to plan and manage people's care packages and develop rotas for care staff. A variety of information had been input into the system such as people's preference on whether they wanted a male or female staff and the regular staff in attendance so that when rota's were planned the system would automatically select the appropriate staff member to attend the call. The system was also able to look at the locality of care staff available in relation to the locality of the person receiving care so that care shifts were booked in one particular area for care staff living in that area, which would reduce travelling time and distance travelled. Rotas, once developed, detailed the person's details and a brief summary of the care and support required with any associated risks.

The provider was currently in the process of implementing a software package which would automatically alert the field care supervisor and the registered manager of when reviews, supervisions and appraisals were due which would eliminate the need of a manual overview which at present required continuous oversight. The programme would also be able to send updates, memos and training and policy updates to staff which was relevant to their work. Staff would then need to confirm, through the system, that they have read and completed the assigned work so that managers could confirm learning and development had taken place.

We saw the results of the recent staff questionnaire, which included questions around recruitment, induction, training, management support and staff development. The overall feedback was positive. Comments from the survey included, "I've got good training with Jay's," "I always read care plans. It helps me to know my client's needs," "We have regular supervisions," "The training is very informative" and "They [Jay's Homecare] are doing well already, keep it up."