Platinum Home Care (South Coast) Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 5 and 9 May 2016 and was announced.

Platinum Homecare (South Coast) Limited is a family-run domiciliary care service that provides support to people in West Sussex, including in Chichester and Southbourne, The Witterings and Selsey. At the time of our visit the service was supporting 70 people with personal care.

The service 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 did not always receive safe support with their medicines. Records of administration for some people were unclear and that guidance on 'as needed' (PRN) medicines and topical creams was insufficient. Other aspects of medicines were managed safely. Prior to our inspection the registered manager had nominated a staff member to monitor how people were supported with their medicines and to ensure that assessments were up to date. By the second day of our visit, staff had started to complete written guidance to staff on PRN medicines.

The service was able to respond quickly to provide additional care and to meet people's needs. People and relatives spoke highly of the service and valued the flexibility they were able to offer in scheduling additional support at short notice. People were involved in planning their care and determining how they wished to receive care and support. People's care was reviewed and any changes communicated quickly and effectively to staff.

People were asked for their views on how the service was run and felt able to approach staff and management with any concerns or ideas. The registered manager responded proactively to make improvements and adapt care to meet people's needs. People knew how to make a complaint and were assured of a full and prompt response.

People spoke highly of the staff who supported them and valued the continuity of care that they received. Staff supported people to be as independent as they were able and were mindful of their privacy. People told us that staff respected them.

There were enough staff employed and the rotas were managed effectively. Staff understood local safeguarding procedures. Risks to people's safety were assessed and reviewed.

People had confidence in the staff who supported them. Staff received training to enable them to deliver effective care. They were supported in their roles and professional development by a system of supervision. Staff understood how consent should be considered in line with the Mental Capacity Act 2005. Staff

supported people to prepare meals and to eat and drink if required. Where people could benefit from additional support, referrals were made to other healthcare professionals such as the GP, district nurses or occupational therapist.

The registered manager monitored the quality of the service and used feedback from people and staff to identify improvements and act on them. Senior care workers carried out spot checks on staff and reviews with people in the community. The registered manager acted openly and transparently and responded quickly to any areas of concern. This helped to ensure that the service made continuous improvements and delivered care that was of a consistently good standard.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not safe in all respects.

Medicines were not always managed safely and further guidance on individual support needs was required.

People said they felt safe. Staff had been trained in safeguarding so that they could recognise the signs of abuse and knew what action to take.

Risk assessments were in place and staff made referrals for advice or additional equipment to help mitigate identified risks.

There were enough staff to cover calls and ensure people received a reliable service.

Is the service effective?

Good

The service was effective.

Staff were knowledgeable about people's care needs. They had received all necessary training to carry out their roles.

Staff understood how consent should be considered and people were consulted on the care they received.

People were offered a choice of food and drink and given appropriate support if required.

The provider liaised with health care professionals to support people in maintaining good health.

Is the service caring?

Good

The service was caring.

People received person-centred care from staff who knew them well and cared about them.

People were involved in making decisions relating to their care. They were encouraged to pursue their independence.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

The service was able to respond quickly to adapt or increase care to meet people's needs.

People's care had been planned and reviewed to reflect their needs and preferences.

Staff knew people well and understood their wishes.

People were able to share their experiences and were confident they would receive a prompt response to any concerns.

Is the service well-led?

Good

The service was well-led.

The culture of the service was open and friendly. People and staff felt able to share ideas or concerns with the management.

The management team were readily contactable. Staff were clear on their responsibilities and felt they were listened to and valued.

In addition to people's feedback, the registered manager used a series of checks on care records and unannounced visits to monitor the delivery of care and ensure that it was consistently of a good standard.

Platinum Homecare (South Coast) 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 5 and 9 May 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure that someone would be in.

One inspector and an expert by experience undertook this inspection. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service. The expert by experience at this inspection had expertise in older people and dementia care.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed two previous inspection reports and notifications received from the registered manager before the inspection. A notification is information about important events which the service is required to send us by law. We used all this information to decide which areas to focus on during our inspection.

We visited the office where we met with the registered manager, deputy manager, trainee manager, a care coordinator and senior care worker. We looked at six care records, medication administration records (MAR) and visit record sheets. We also reviewed seven staff training and supervision records, five staff recruitment files, quality feedback surveys, minutes of meetings and staff rotas.

We visited three people in their homes and met with a further three care workers. We telephoned 20 people,

three care workers and three relatives to ask for their views and experiences. We also received feedback on the service from the local authority contract monitoring and support brokerage teams who had involvement with the people the service supported.

Platinum Homecare (South Coast) Limited was last inspected in September 2013 and there were no concerns.

Requires Improvement

Is the service safe?

Our findings

Some aspects of how medicines were managed required improvement to ensure that people received appropriate and safe support. We found that records of administration for some people were unclear and that guidance on 'as needed' (PRN) medicines and topical creams was insufficient. Topical creams are applied directly to the skin and prescribed for use in particular parts of the body to treat specific conditions.

Where people were prescribed topical creams, the care plans did not always contain consistent information about their administration. In one person's initial assessment we read that a particular cream should be applied to their 'arms, legs and feet' but in their care plan it stated only 'legs and feet'. Their medication assessment made no reference to support with topical creams. In the daily notes for this person we saw that several creams were prescribed and that no guidance was given as to where and how often these should be applied. The records indicated that there was variation in how frequently and to which parts of the body the creams had been used. Some medicines were prescribed on a PRN basis. The medication policy used by the provider stated that, 'A specific plan for administration must be recorded on the Protocol for administering 'when required' medicines'. These protocols had not been completed which put people at risk of receiving inconsistent support and not receiving their medication as intended by the prescribing GP.

Records of medicines administered were generally complete and clear. We found, however, that some people received support with their medicines from both their relatives and staff. Staff signed when they had administered the medication and ticked when they had seen the family do so but there was no record if medicines had been given by the family when staff were not present. This had resulted in gaps on the medication administration record (MAR) and it was not certain that the person had received their medicines as prescribed. The medication assessment for these people stated that staff would administer their medicines, meaning that the service took responsibility. We discussed with the registered manager how this method of joint administration might put people at risk of incorrect administration.

The registered manager had recently appointed a senior care worker to take responsibility for medicines. This role included ensuring that people's assessments and records were correct and that staff were confident and understood what was required of them. This staff member told us that they would be checking medication assessments to ensure they accurately reflected people's support needs. She said, "I've got more office hours now so it will be easier to keep on top of it". She also told us, "I text all the care staff to say, even if they only have creams, we need a medication file". We noted that medication competency assessments had been carried out for all staff between November 2015 and April 2016. By the second day of our visit, staff had started to complete PRN protocols. These included details of the medicine, when it should be given, the gap between doses and when medical advice should be sought.

People told us that they felt safe and were happy with the care and support they received. In the provider's annual survey all respondents (12) said they would be happy to recommend the service to others. Staff had attended training in safeguarding adults at risk. They were able to speak about the different types of abuse and describe the action they would take to protect people if they suspected they had been harmed or were at risk of harm. One staff member said, "I'd let the office know straight away. We've got a chart; it's a picture

of the body. We have to mark down where they (bruises/marks) are on the body". Where staff supported people by purchasing items for them, a clear record of transactions along with the receipts had been maintained. Staff told us that they felt able to approach the registered manager if they had concerns. They also knew where to access up-to-date contact information for the local authority safeguarding team. One staff member told us, "They (the office) take safeguarding very seriously".

Risks to people's safety were assessed. People's care plans described each risk that had been identified and instructed staff on how support should be delivered to minimise the risk. This guidance was specific to the individual they were supporting. Examples included the use of thickener in drinks to reduce the risk of choking, checking and creaming of pressure areas to reduce the risk of skin breakdown and not administering medicine to a person if they had been drinking alcohol. Where people used equipment to help them transfer, details of the hoist and slings were included. Staff were directed to check for frayed material on the sling and to only use the hoists in pairs.

Staff were mindful of people's safety. We observed staff assisting one person to transfer to a wheelchair using their walking frame. This was done safely. Staff ensured that the brakes were on and reminded the person to keep their elbows in when going through the door way. When the person returned to their armchair, staff ensured that there were no creases in the seat cover which might have been uncomfortable for the person or caused damage to their skin. Staff shared examples of how they helped to protect people from unwanted callers and carried out monthly checks on people's care alarms to ensure that they were working. In the daily notes for one person we saw that staff had arranged for an engineer to visit and repair the heating in their home.

People received consistent support from a regular staff team. They told us that staff were reliable and that they generally arrived on time. One person told us, "Staff are not too bad for timing, traffic or an accident can hold them up". Another said, "I get a booking sheet every week, it's helpful to have it here". The registered manager explained how they considered their staffing capacity carefully before taking on new clients. She told us that it was important to retain some spare capacity in order to respond to changes in people's needs.

Staff recruitment was generally by word of mouth. The registered manager told us that they had not struggled to attract new staff. Staff recruitment practices were robust. Staff records showed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. One staff member told us, "I shadowed for a while, you have to wait for your police check". These measures helped to ensure that new staff were safe to work with adults at risk.

Good

Is the service effective?

Our findings

People had confidence in the staff who supported them. One person told us, "I depend on the carers coming, we tried other companies but Platinum is the best". Another said that it was, "All working very well". Staff felt confident in their skills and abilities and told us that they had received training relevant to their role. Training was delivered at the provider's office by an external training company. The room was equipped with a bed, hoist, wheelchair, stand aid, slings and personal protective equipment (PPE). Courses made mandatory by the provider included safeguarding, moving and handling, first aid, communication, personal care, health and safety, fire, medication, infection control and dementia care. Staff told us that trainer was, "Brilliant". The provider had a system to monitor staff training and had appointed a staff member to oversee this. We saw that staff training was mostly up to date. Where staff members were due to attend refresher training, this had been booked. The registered manager said, "Gaps are now hotly addressed".

Staff were given opportunities to further their training and professional development. New courses or training opportunities were shared with staff and discussed at supervision meetings. One staff member had taken up training opportunities to further their knowledge in nutrition and health and the management of diabetes.

New staff underwent a period of induction, during which time they shadowed experienced staff and completed the Care Certificate, a nationally recognised qualification covering 15 standards of health and social care. New staff told us that they felt supported. One said, "I'm seven weeks in and I'm still on induction/shadow. I feel supported". Another told us, "I did feel ready. I'd met most of the people before". A third said, "I felt supported at the start. I knew that I could always phone them".

Staff were enthusiastic about their work and felt supported in their roles. One said, "They're pretty good. They're always there if you need them". Another told us, "The office are very helpful. They don't make you feel bad for even the slightest query". Staff attended supervision meetings where they discussed their performance and professional development. We saw that any actions were recorded, such as when a staff member expressed a wish to pursue further training or if aspects of their performance required attention. One staff member told us, "It gives an opportunity to talk about any queries". In addition to one to one supervision meetings, staff performance was monitored through a series of spot checks and observations. This looked at their dress, whether they read and followed the care plan, the records they kept and whether the person was happy with the care they received. Any issues were addressed directly with the staff member and, if relevant to others, shared in the weekly memo to all staff.

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

We checked whether the service was working within the principles of the MCA. The registered manager had a clear understanding of the MCA and their responsibilities. Staff were able to describe how they considered people's capacity and consent in their daily work. They spoke of how they encouraged people with their personal care but that they would never force them. In one person's care plan we read, 'If (name of person) declines help sometimes if you say that her granddaughter (name) has asked you to go then she may be happy for you to help her'. We observed that staff sought consent from people before assisting them.

People had been involved in planning their care and had usually signed their care plans and reviews to demonstrate their agreement. One person had signed to say that they wished to use bedrails as they felt more secure. Where people had appointed a representative to act on their behalf, this was clearly recorded. We saw that staff had been involved in a best interest meeting for one person regarding their housing, which was in a poor state of repair. As a result the person moved to temporary accommodation whilst renovations were made. Another best interest meeting was planned to decide on accommodation options for a person who lacked capacity to make this decision and who it was felt was no longer safe living independently. This meeting was to involve the family and other professionals to reach a best interest decision on behalf of the person.

Some people were supported to prepare meals and drinks and to ensure that they ate and drank enough. People's care plans included details on their dietary preferences. We accompanied a staff member on a lunchtime visit to one person. We observed that they offered them a choice of meal and encouraged them to eat it. One person told us, "They make my lunch, a freezer meal, and they know I always want two cups of tea, which I get".

Where there was a concern that people may not be eating sufficient amounts, staff maintained a record of the food served and detailed when it had not been eaten. For example, 'Still got sandwich and meal in fridge and I think he hadn't eaten at all – will inform office'. We saw that the office staff had shared this concern with the care workers due to visit the person to ensure that their nutrition was closely monitored. The next day it was reported that the person had eaten breakfast and lunch. A family member of this person had written a letter of thanks to the agency. It read, 'I visited on Sunday and found him well. He has gained some weight which I think must be thanks to Platinum ensuring he eats regularly, so thank you for looking after him so well'. For another person, the registered manager had suggested shortening the morning call, where staff often finished early, and increasing the duration of the tea call so that staff could stay with the person as they ate their evening meal. We found that the staff were proactive and ensured that people ate and drink sufficient amounts.

People were supported to maintain good health. People had been referred to the GP, district nurses or occupational therapist (OT) when required. For example, a GP referral had been made when staff noticed a lump under one person's breast and a district nurse appointment had been made for another person to have their ears syringed. Staff had attended when the occupational therapist had visited people so that they could demonstrate and receive advice on the use of equipment. A representative from the support brokerage team at the local authority told us, 'Platinum were quick to identify that this gentleman needed additional equipment in the home and the risk assessor arranged a joint visit with OT to enable this. They also said, 'My experience in general with Platinum has been very professional, courteous and timely'.

Good

Is the service caring?

Our findings

People spoke positively and enthusiastically about the staff who visited them and many referred to "their carer" when speaking. One person had written to the provider to express their thanks for the continuity of support that they received and said that they considered staff to be more like friends than care assistants. Another person had written in the provider's questionnaire, 'Carers are lovely, dedicated – nice to have carers that I know'. A third wrote, 'I look forward to the visits'. People told us that the staff were "Marvellous" and, "Super-duper". One said, "I was asleep when they arrived, they gently woke me, so as not to frighten me". Another told us, "They are very good to me" and described them as, "Comfortable, pleasant and cheerful".

When we visited people in their homes we observed that they had a friendly and easy relationship with staff. Staff were able to chat about people's friends and relations and enquired after what they had been doing during the morning. In the evening, we could hear laughter coming from the bathroom when staff were assisting a person to get ready for bed. Staff were thoughtful and considered the person's needs, for example by turning lights on before dark as the next visit wasn't due until after nightfall.

The registered manager understood the importance of the relationships between staff and the people they supported. In one case, when a staff member's car was out of action, the service paid the taxi fares to ensure that people's care was not disrupted. For another person who was nearing the end of their life, the staff who supported them prepared by attending a course in end of life care. The registered manager told us that the person's wish of remaining at home had been fulfilled.

Many people told us how staff had gone above and beyond their duties to support them. One staff member described how they had been visiting a person in hospital and liaising with their family who lived some distance away. They told us that they had been visiting this person for over ten years and were happy to visit them in hospital in their own time. Another staff member said, "I'll pop to the shop for people or do extra little things to help out". A relative had written to thank staff for noticing and reporting a loose roof tile following storm winds. Another had called to say that, 'Care staff have gone above and beyond the call of duty looking after her mother over the last few weeks'.

People were involved in planning their care and their preferences had been clearly recorded in their care plans. In some cases staff were prompted to check with the person as to their daily preference. For example, 'Ask (name of person) if she wants her bed made or left open'. One person told us how their regular care worker sensed how they were feeling and responded appropriately. They told us that the care worker seemed to sense when they were tired and offered to help manage their stoma bag, which was something they usually did independently. They told us, "This is a very personal issue which she deals with excellently. She makes a real difference". Where people had a preference for or did not wish to be visited by certain staff members this could be recorded on the system, for example if a female did not wish to receive support with personal care from a male member of staff.

People were encouraged to be as independent as they were able. One person told us, "When getting ready

for bed the carers let me do as much as I can with changing my clothes. They help me, but let me do what I can for myself". Another person explained how staff supported them to use their tumble dryer which was located down some steps. They explained that they were able to remain in their own home and do their laundry but with assistance. Care plans directed staff to promote independence. We read, '(Name of person) likes to do as much for herself as she can manage, carer to assist with what she cannot do' and '(Name of person) will wash himself while both care assistants are downstairs and will call out when he is ready for some help to put on his t-shirt'. A staff member said, "You help as much as you can but you can't take their independence away from them".

People told us that staff respected their privacy. One person said, "I feel respected". Another said that the staff were, "All lovely, like friends, we haven't had one who is disrespectful, they don't look down on you". A relative remarked that although they have a key safe, "The carers always ring the bell first and are very respectful". We saw that in the provider's survey from 2015, all 12 respondents had answered 'yes' to the question, 'Are you treated with dignity and respect at all times'. Staff observations included checks on how staff approached and respected people. In one observation it was noted that a staff member talked over the person they were supporting. This was addressed with the staff member. We found that people were treated with dignity and respect and that the provider took an active approach to monitoring this.

Good

Is the service responsive?

Our findings

People were involved in determining the support they wished to receive and were able to make adjustments to suit their preferences and lifestyle. Each person's needs were assessed and the support they wished to receive described in a care plan. The assessment covered access to the home, medication, mobility, continence, dietary, mental health, communication and social needs. Where people lived with a particular condition this was clearly explained to staff, along with how it affected the person's independence. In one care plan we read, '(Name of person) will then transfer to her wheelchair. It does take (name) a little while to transfer as she has left sided weakness from her stroke'. In another care plan we read that the person's abilities varied from day to day. There was a support plan for a 'good day', a 'day with reduced mobility' and equally for a 'bad day'. The support required ranged from assistance to walk with a frame through to being supported in bed.

The service was able to adapt to meet people's needs by responding quickly to requests for additional visits. For the above-mentioned person, the number of care visits was increased on a day when they were unable to get out of bed. The service was able to respond quickly by slotting additional calls in to ensure that the person was comfortable and received appropriate support. For another person, the service had arranged emergency overnight cover. This then moved to providing 24-hour care over a short period before the person passed away. The family of this person had expressed their gratitude to staff for making it possible for their relative to remain in their own home. A third person's calls had been extended by 30 minutes in the morning, lunchtime and evening so that staff could stay with the person and ensure they ate. A fourth person had been supported by a staff member to vote in the local elections and their call time had been extended to facilitate this. In the coordinator's diary we saw that other one-off adjustments to call times, such as to accommodate hospital appointments or social engagements had been fitted in. Several of the people we spoke with told us that they had been able to adjust their calls times to better suit their needs. One relative told us that they had rung the office to say that the morning visit was too late. They told us, "The owner rang back in half an hour; she sorted it out and changed the times for me". Another had written to the service to say, 'Thank you for making mum's evening call earlier'.

Care plans included detail on individual preferences, such as the person's preferred name and names of others involved such as family members, cleaners or gardeners. In one we read, 'When you talk to him about her (relative) you can use this nickname and he will better understand who you are talking about'. There was also detail on specific wishes or requests such as that a person liked to have all their electrical switches turned off. Staff told us that the care plans were useful and that they were able to obtain copies from the office if they were due to visit a new person or someone they had not seen for some time. One staff member told us, "Usually if it is someone I don't know, I get a print out from the office and call another carer who knows them well".

When a person's needs changed this was communicated effectively to staff. Any immediate changes were communicated to staff via text message. A recent example was when a person's main family carer went into hospital, staff were informed that they needed to prepare meals for the person. This information was then also included in a weekly memo to all staff which went out on a Friday. The memo included updates on

people's care and guidance for staff, including if a person was not eating well or if they required help with new tasks, such as putting their stockings on. Where significant updates had been made, staff were prompted to read the new care plan. We read, 'A new risk assessment is in place as there has been a big change in care needs, please read and follow'. There was a system in place to ensure that people's care was reviewed on a regular basis, and a minimum of once per year. The review involved people and, if they wished, their relatives. We saw that the discussion included call times, any changes to dietary needs or preferences, how the person felt about the care team and whether they had any questions. We saw that staff had taken action in response to feedback and made the necessary updates to their care plans.

People told us that any concerns were quickly addressed. Contact details for the office, along with emergency contact numbers and a copy of the complaints policy, were included in each person's home file. One person said, "I had some admin problems with invoices, now sorted". A representative from the support brokerage team at the local authority told us, "Initially, there were issues with the call timings and consistency of carers which we addressed with the provider and they reacted quickly and to the family's satisfaction". We looked at the records of complaints and saw that complaints received had been responded to and resolved in accordance with the provider's policy. Any learning or action points were communicated to staff. One person said, "I have nothing to complain about; care wonderful, nice girls".

Good

Is the service well-led?

Our findings

There was an open culture at the service. People and staff felt able to approach the management team and felt valued by them. One staff member said, "I went to a staff meeting and had a good chat with (the registered manager). They listened and explained. I found them really approachable". Another told us, "They're good to me. They're accommodating". The registered manager acknowledged issues openly and was quick to offer thanks and recognition. In a letter to clients the registered manager thanked them for their patience over the winter months where they had been changes in rotas due to staff sickness. Staff were thanked in turn for their help in covering absences. A new system of rewarding staff loyalty was in place by offering additional leave after three, five and seven years of service. The registered manager told us, "The door is open. Staff are happy to talk to us".

The registered manager was supported by a deputy manager, office team and senior care workers in the field. Senior care workers tended to work in one geographical area but were also asked to cover the other areas to ensure that they were able to respond effectively to any queries when they were 'on call' with the emergency phone. When we asked the registered manager what challenges they were facing, she replied, "Convincing staff that we are here for them". We saw that in response to staff feedback about a lack of communication, staff meetings had been moved to a monthly frequency. A new administrative position had also been created in the office to free up management time. In the provider's survey, one person had written, 'Lucky to have your very good service'.

The registered manager, and owner of the company, shared her time between the agency and a residential service located nearby. She told us that she tended to split her days to ensure that she was available to each service. People praised the registered manager and told us that she was caring and helpful. One said, "The beauty of Platinum is it's owned by a person not a company, she came out to see me". Another told us, "The owner came to see me, she's marvellous, it's so well run".

The registered manager had a system to monitor the quality of the service that people received and to make improvements. Staff met with people to review their care and senior care workers monitored staff competence via a system of spot checks. Daily care records and MAR were returned to the office monthly and checked to see that the care delivered matched with the care plan. We noted that issues such as a missing risk assessment and the fact carers had changed a pain patch when this was not authorised had been picked up and addressed. Following a safeguarding incident whereby a person's medication was not available, an additional call was generated on the system so that staff were formally allocated the task of collecting the monthly prescription.

The registered manager completed a monthly analysis of care calls, compliments and complaints and recorded her findings. In the January analysis we read, 'Huge increase in sickness due to chest virus/flu has resulted in some late calls due to fitting visits in to cover staff sickness'. By February this had improved and the registered manager recorded, 'The trend towards a worsening service has halted'. The year's performance was reviewed and an annual report completed. In addition to the late or missed calls, compliments and complaint this report considered the findings of the annual customer and staff survey.

The annual surveys had been sent by the provider to people and staff in August 2015. The analysis was positive but the registered manager noted that improvement was needed in continuity and timing of calls. In order to assess the performance of the service, an additional set of 'mini questionnaires' were sent. This asked specific questions about consistency of care staff and regular visit times. The analysis of results showed an improved picture.

The registered manager took prompt action to make improvements to the service. Comments in the surveys returned had been acted upon. For example a request for a changed call time had been passed to the care coordinator and a review had been requested for one person who staff felt would benefit from a smaller size commode. The registered manager had identified that there were discrepancies in some medication records and that staff supervisions not been taking place at the frequency stipulated by the provider. In response, she had delegated responsibility and allocated office time to nominated staff to monitor these areas of service. Staff used a whiteboard in the office to record weekly tasks and actions for immediate attention. The registered manager told us, "It (action) tends to be pretty instant". A staff member told us, "There are more people going out and checking things".

We found that the registered manager had effective systems in place to make an honest appraisal of the service. She responded quickly and transparently to any concerns. This helped to ensure that the service was of a consistently good standard and that further improvements were made.