Sentinel Homecare Limited

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Inspection report

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Date of inspection visit:
02 June 2017
05 June 2017
06 June 2017
07 June 2017
08 June 2017

Date of publication:
26 June 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Sentinel Home Care provides a range of domiciliary care services to people throughout the Bradford area from an office close to the city centre. The agency provides care and support to a wide range of people including older people, people with a dementia related condition, and people with learning or physical disabilities.

The inspection took place between the 2 and 8 June 2017 and was announced. This meant we gave the provider a short amount of notice that we would be visiting the office in order to ensure a manager was present.

A registered manager was in place. 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.

At the last inspection in November 2016 we identified significant concerns. Staff were cutting visits short and care and support tasks were not getting completed. We found there were insufficient staff deployed to ensure a high quality and reliable service. We identified five breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service 'inadequate' overall.

At this inspection we found improvements had been made. The service had reduced the number of care packages provided, reorganised rotas and included travel time. Electronic call monitoring had been introduced as well as more rigorous checks on staff practice. This had the effect of improving the quality, consistency and reliability of the service provided.

Feedback from people who used the service was improved with people saying care needs were met by the service. Some people still raised some concerns about the timeliness of staff, but overall we found this was a much improved picture.

People told us they felt safe using the service. Safeguarding procedures were in place and had been used to help keep people safe. Staff had received training in safeguarding vulnerable adults.

Whilst some improvements had been made to medicines systems, medicines were not consistently managed in a safe way. There was not always a clear record of the medicine support provided to each individual person.

Risks to people's health and safety were assessed and clear and detailed risk assessments put in place. However some of these required updating when people's care plans changed.

There were sufficient staff to provide a reliable and consistent service. Safe recruitment procedures were in

place to help ensure staff were of suitable character to work with vulnerable people.

People spoke positively about staff and said overall they had the skills and knowledge to support people effectively. Staff received a range of training and support.

Some people said they received consistent care workers, others said this was not the case. We saw work was being undertaken to further improve the consistency of care workers.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent to care and support was sought.

People said staff were kind and treated them with dignity and respect. Staff we spoke with demonstrated good, caring values.

People's care needs were assessed and detailed and person centred plans of care put in place to help keep people safe. These provided step by step instruction to assist staff in providing appropriate care.

People said they received appropriate care from the service. Most care visits took place at a consistent time with staff staying for the required amount of time. However some people still complained about the timeliness of the service. We concluded this was an improving picture due to changes made to rotas and the introduction of the electronic care system.

Complaints were logged and action taken to try to address them. The number of complaints about the service had reduced since the last inspection.

We found an open and honest culture within the service, with the management committed to continuous improvement of the service. People and staff said improvements had been made to the service.

A range of audits and checks were undertaken to help improve the service. Some of these needed to be more robust to ensure the remaining issues we found with documentation were rectified.

People's feedback was regularly sought and used to make positive changes to the service.

We identified one breach of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked the provider to take at the back of the full version of the report.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

People and relatives said medicines were given as prescribed. However, a complete and accurate record of the medicine support provided to people was not always kept.

The service and staff understood how to keep people safe. Risk assessment documents were in place although some of these required updating.

There were now sufficient staff deployed in the right places to ensure people received a consistent service. Safe recruitment procedures were in place.

Is the service effective?

Good

The service was effective.

Staff had received training in subjects relevant to their roles. Most people said staff had the right skills and knowledge to care for them effectively.

People were provided with appropriate support to eat and drink. Information in care plans provided clear instruction on the required support.

People's healthcare needs were assessed and plans of care put in place. Staff liaised with appropriate healthcare professionals when people's needs changed.

Is the service caring?

Good

The service was caring.

Most people spoke positively about staff and said they were treated with dignity and respect.

People were listened to and the service had made improvements to address people's comments and views.

People's independence was assessed and where appropriate

promoted.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Improvements had been made to the responsiveness of the service. We would need evidence of sustained improvement before we could conclude the service was responsive.

People's care needs were assessed and clear and detailed plans of care put in place. Most people said care needs were met by the service.

Improvements had been made to the timeliness of the service although some people still complained of late or rushed calls.

A system was in place to log, investigate and respond to people's complaints. Most people said these were now dealt with appropriately.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service would need to ensure sustained improvement and remaining documentation issues addressed before we could conclude it was well led.

We saw evidence audit and checking systems were being used to improve the quality of the service. Some of these required further refinement to ensure they were consistently effective.

People's feedback was sought and used to make changes to the quality of the service.

Sentinel 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.

Our inspection took place between 2 and 8 June 2017 and was announced. The provider was given a short amount of notice because the location provides a domiciliary care service and we needed to be sure management would be present in the office. On 7 June 2017 we visited the provider's offices. Between 2 and 8 June 2017 we made phone calls to people, their relatives and staff.

The inspection team consisted of two inspectors and two experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The experts used on this occasion had experience of domiciliary care.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received from the home. We contacted the local authority safeguarding and commissioning departments to get their views on the service. The service had completed a Provider Information Return (PIR) which is a document which tells us about the service, what it does well and improvements it plans to make. We used this to assist in the planning of the inspection.

During our visit to the provider's office we spoke with the registered manager, the provider and the quality manager. We looked at the way people's medicines were managed, looked at elements of 13 people's care records and viewed other records relating to the management of the service such as call logs, quality assurance audits, staff recruitment files and training records.

Between 22 May and 1 June we spoke on the telephone with 15 people who use the service, 7 relatives and 16 care staff.

Requires Improvement

Is the service safe?

Our findings

At the last inspection in November 2016 we found medicines were not managed in a safe or proper way. There were a lack of medicine administration records in place and as a result some relatives said it was difficult to establish whether their relatives had received their medicines. At this inspection we found some improvements had been made but a complete record of the medicine support provided to people was still not consistently in place.

People and relatives said medicines were managed in a safe and appropriate way. Following the last inspection, medicine administration records (MARs) had been put in place where staff supported people with medicines from a dosette box. Dosette boxes have compartments stocked with multiple medicines, divided by time and date to make medicine administration easier. Staff told us they had received MAR training, felt the new MARs had simplified the process of medicines administration and were easy to understand. One staff member told us, "MARs are in place now and are getting checked regularly. We get questioned if they're not signed." MARs were generally well completed and showed people had been offered consistent support with their medicines. Care workers were required to sign the MAR chart to state all medicines in the dosette box had been administered and a list of the medicines administered was attached to the MAR chart. In some cases, this provided a full record of the medicine support people were provided with, however this was not consistently so. Some medicine lists did not detail the time of day each medicine was provided, meaning it was unclear at what time of day it had been offered. This meant a complete record of the support provided was not in place.

Care records provided information on the medicines people were prescribed, however this was not individualised for each of the daily visits. Conflicting information on the medicines people were prescribed was sometimes recorded on the medicines risk assessment and care plan. Some MAR charts were hand written, however full details of the dose and frequency were not always recorded. One person was prescribed a medicine to be given on an empty stomach. There was no information within the person's risk assessment to show how this was to be achieved.

In most cases records for topical medicines such as creams were now in place and care records provided instructions to staff on when to apply these medicines. However, we saw one person who was prescribed a topical cream did not have a corresponding MAR in place even though the updated care record instructed staff to sign this upon application.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) 2014 Regulations.

Where people were prescribed medicines to be given at particular time intervals we saw this was considered during care planning and audited to make sure it was adhered to. In most cases we found gaps between administration were appropriate although in one case the early evening and late evening calls were too close together.

MAR charts were regularly audited to ensure people received their medicines as prescribed. We saw in some cases these were effective in identifying discrepancies around documentation. However further work was needed to ensure the remaining areas for improvement were addressed.

Most people we spoke with told us they felt safe in the company of staff. One person said of staff, "Yes they are brilliant." Another person said, "They are good, I do feel safe," and a third person said, "Yes, no problem with safety." However a fourth person told us, "Safety is ok, one or two care workers are very cheeky to me, I do not like this." Relatives also said people were safe. One relative said, "My relative is totally safe with the care workers," and a second said, "We do not have issues about safety." A third relative commented, "Some of the staff are excellent, I've no concerns about safety, they are like part of the family." One person said they had previously complained about a care worker who they did not, "Get on with," and the office had ensured they were no longer sent.

Staff had received training in safeguarding and understood how to identify and act on allegations of abuse. They told us the management were approachable and they felt able to raise concerns with them. We saw evidence safeguarding issues were taken seriously by the management, referral was made to the local authority and the Care Quality Commission (CQC) was notified. Safeguarding incidents were investigated and action taken including commencing disciplinary procedures where appropriate to help reduce the likelihood of a reoccurrence.

Risks to people's health and safety were assessed and risk assessments put in place. These were detailed and covered areas such as skin, nutrition, mobility and the environment. We found some of these required amending as they were not always updated as care plans changed which meant information in care plans and risk assessments sometimes differed. For example, we saw in one person's updated care records they required a walking frame for their mobility. The mobility risk assessment still stated they walked with the aid of a stick and not a walking frame. This could cause confusion for staff providing care and support. We raised this with the quality manager who told us they would ensure risk assessments were brought up-to-date and in line with care plans.

Records showed and people told us that when two members of staff were required for moving and handling this was adhered to. Staff confirmed this and said there was a 'no tolerance' policy of attending a double up call on their own.

The service had recently implemented electronic call monitoring (ECM) which meant staff logged into calls when they arrived at people's properties and logged out when they left. Although not all people wanted this in place, where people had consented, it provided a key safety net updating the office in real time as to the timeliness of calls. Implementation of this was in its early stages with the registered manger telling us and records confirming that action still required to ensure staff consistently logged in and out of the system when entering and leaving people's homes. Where ECM was in use, staff told us they generally found it an easy system although some reported delays in logging in if the home phone was in use. We saw the number of complaints about late arrival or missed calls had reduced since the introduction of ECM and one staff member told us some the people they provided care and support to had commented about how staff now stayed for the appropriate amount of time. We saw if ECM alerts were raised at the office about staff arriving late or missing a call, they were called into the office for a meeting to discuss why this had occurred.

At the last inspection we found there were not enough staff deployed to ensure a reliable and consistent service. At this inspection we found improvements had been made. The service had reduced the amount of care packages and now had sufficient quantities of staff to provide consistency. Rotas and care runs had been reorganised, were better arranged geographically and now contained travel time between calls. This

helped enable staff to stay with people for the required amount of time which had been an issue previously. Staff confirmed rotas were now much better, realistic and achievable although some staff said travel times could be problematic at peak traffic times. Feedback from people about the reliability of the service was improved, although some people still complained of late calls. Comments about timeliness included, "Yes they mostly come on time, odd occasions they have been late due to traffic or emergency", "Sometimes they do, sometimes they do not, today they came on time", "Pretty good, most of the time on time, odd occasions late," and, "On time most of the time, only odd occasions late, they tell me." One relative said, "Weekends are a problem, the care workers come late." On reviewing daily records of care we saw evidence timeliness was generally good and calls consistently took place. We spoke with the registered manager who told us although they were constantly recruiting, staffing levels had improved since the start of the year. We concluded sufficient staff were deployed to meet people's needs.

A robust recruitment process was in place. This included obtaining at least two positive references and information from the Disclosure and Barring Service (DBS). Interviews were held with scenario based questions to check people's suitability for the role and any gaps in employment were explored. This meant people employed by the service were checked for their suitability to care and support vulnerable people.

People and relatives generally told us that staff adhered to good hygiene and infection control techniques. They said care workers all wore appropriate gloves and aprons when they attended the service users. However one person told us that staff did not always adhered to recognised techniques saying, "Some staff don't put used pads in a bag before they put them in the bin. They smell so I contacted the office, it changed for a while but then they got new staff and it started again."

Good

Is the service effective?

Our findings

At the last inspection in November 2016, we received poor feedback about the skill and knowledge of staff. At this inspection we found improvements had been made. We saw the service had put in place a number of initiatives to improve this aspect of the service. This included more frequent training for staff, increasing monitoring of staff through supervision and spot checks processes and seeking more feedback of people's experiences of their care workers.

A training matrix was in place which highlighted when training was due for staff. We saw training was mostly up to date or booked. Training was completed at the service premises and provided by internal staff who had completed train the trainer courses. Staff we spoke with told us they thought the training equipped them with the appropriate skills to provide effective care and support. Staff told us they were encouraged to undertake further training. For example, one staff member told us how the service was supporting them with gaining a diploma in health and social care.

New staff members completed a five day induction which included introduction to the Care Certificate, company policies and procedures, food hygiene, infection control, catheter care, continence management, the Mental Capacity Act, safeguarding and dementia awareness. Staff shadowed an experience member of staff for at least two shifts, dependant on their experience and had to be approved before being allocated their own rota. A probationary period of nine months was in place during which spot checks and supervisions were carried out to assess the staff member's competency and suitability for the role.

A focus on increased training was reflected in improved feedback from people and relatives. One person said, "They are skilled, I have no problems." Another person said, "All the jobs done, some new ones are not up to scratch, I talk to them, tell them, they then get better each time they come, they have changed for the better now." A third person said, "The company have provided great care workers, very supportive." Relatives told us, "They are trained, my relative has never complained", "We had serious issues with certain carers, we made an official complaint, the company sorted this issue out, we do not get these carers again," and, "The care workers are very skilled."

Supervisions and spot checks took place on a regular basis. Staff we spoke with confirmed they received supervisions approximately every three months or sooner if a specific need was identified. We saw evidence these took place from reviewing staff files. Staff told us these were used as an opportunity to discuss any issues and identify any training or support needs. There was a supervision and spot check matrix in place which highlighted these were mostly up to date. Spot checks were carried out to check if staff arrived on time, were correctly dressed, carried out tasks and treated people with dignity and respect. We saw where areas for improvement had been identified actions had been taken. We spoke with the quality manager about staff appraisals which were due to be completed annually. We saw some appraisals had not been completed for over 18 months and they confirmed they were aware of this and had been concentrating on supervisions and spot checks since the last inspection. We had confidence this would be addressed.

People provided mixed feedback about whether they had regular care workers. One person said, "Most of

the time, I have the same care worker team," and another person said, "Yes I do have regular care workers, no problems." Other people said they did not always have regular care workers but most people said this didn't pose a particular problem. A person said, "I used to have regular care workers, now I have different faces all week, I have got to know them, but it is hard you need to get to know them, build a relationship up, it is getting better." A relative said, "Different care workers come, we have no problem with this, my relative is happy with all the care workers." Another relative said, "They are good with my relative, we are not bothered having different care workers, they do all the jobs." Some staff told us that they would like to see greater continuity of clients to improve relationships especially as people appreciated this. We saw further work was being completed to improve continuity including audits in this area.

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. In the case of Domiciliary Care, applications must be made to the Court of Protection. We found no people were currently subject to DoLS.

The provider had a policy and procedure to ensure they supported people in line with the MCA and staff were provided with MCA training. We saw the service was acting within the legal framework of the Act.

We saw evidence of consent in people's care records, including signing of the care record by the person or their relative and consent to share information with relevant bodies. People were asked to consent to electronic call monitoring and their refusals were respected by the service.

People said staff provided good support with food and drink. One person said, "They also make sure I have plenty in to drink," and another person told us, "They prepare my meals, they always ask what I want." Where people were supported with their nutritional needs we saw staff prepared meals of their choice. We saw people who were assessed at risk nutritionally were referred to their GP or the dietician team. One staff member gave us an example of a person they supported who was at risk since they often refused to eat. They told us whilst out shopping with them they would make a remark such as, "I feel hungry. Do you fancy something to eat?" and then stop at a café. This meant the person was encouraged to consume a good diet whilst involved in a social activity.

People's care needs were assessed and appropriate support plans put in place. Care records we reviewed contained detailed information on people's healthcare needs. These provided clear information on how to meet people's individual needs. We saw the service liaised with external health professionals such as district nurses and GP's if people's needs changed.

Good

Is the service caring?

Our findings

The majority of people that we spoke with provided us with evidence that care workers were kind and caring. Comments included, "Brilliant, very caring indeed", "Oh yes they are so kind", "No issues at all, good people," and, "All the care workers I have are good and caring." Relatives also provided good feedback about staff. Comments from relatives included, "Majority are good, the ones that we have had issues with, we made a complaint, they have now not come to see my relative," "We are very happy, [care worker] is very good, like a family to us. The care worker makes my relative very happy indeed," and "Some of the [care staff] are wonderful, you can see they actually love their job."

People and relatives said that care workers recognised the importance of ensuring people's privacy. One relative said, "If I've visitors when they come, they [care staff] work around them and don't do anything when they are there."

Staff we spoke with clearly knew the people they supported and were able to give examples of people's likes, dislikes and how they supported them with their care needs. One staff member told us, "I love my service users; they make my day." Since our last inspection, some staff commented on having a smaller area and regular people they visited which meant continuity was improved and people generally had the same group of care workers. Whilst efforts had been made to improve consistency of carers to people, some people and staff still reported there were too many different carers. We saw the provider was undertaking audits in this area, monitoring how many different carers each person received and taking steps to reduce this. This demonstrated the provider valued the development of good, positive relationships between people and staff.

Care records contained detailed information on people's likes, dislikes and preferences. There was also information about people past lives. Care records were person centred and showed that people had been asked in full about their needs and preferences. This helped staff develop an understanding of the people they were caring for.

People's independence was assessed during care planning and care plans focused around allowing people to do as much as they can for themselves, for example aspects of personal care that they could manage. Daily records provided evidence that staff promoted independence in line with plans of care.

We saw evidence people were listened to and their opinions valued. Following the last inspection in November 2016, we saw evidence the service had refined the way it gathered people's views to ask them specifically about areas of concern identified at the previous inspection. We saw evidence spot checks, telephone interviews and reviews recorded people's opinions in detail. We saw action was taken to address any areas of concern or negative feedback. Care and support plans focused on ensuring people were involved as much as possible in decisions relating to their care and support. Daily records provided evidence people were offered choices on a daily basis and any refusals were respected.

Requires Improvement

Is the service responsive?

Our findings

At the last inspection in November 2016 we found care did not meet people's individual needs. Call visits were cut short and people did not receive the required care and support. At this inspection we found improvements had been made.

People said they received good care from the service which met their individual needs. They said care tasks were completed although three people still said staff rushed. One person said, "The company has got wonderful care workers who are supportive, we have no issues." Another person said, "They provide good care." A third person told us, "Time keeping is not good but what they do, they do well."

People's needs were assessed prior to using the service. This led to the creation of risk assessment and care plan documents which provided a thorough assessment of people's needs in areas such as mobility, personal care, eating and drinking and skin care. Any risks highlighted were clearly displayed within care records to inform staff. Plans of care were very detailed, providing step by step instructions to care workers on the care and support required. Staff told us that care plans were in place in each house and praised the level of detail. For example, one care worker told us the detail and personalisation within care plans was very valuable when going to see people they were less familiar with. This helped staff provide appropriate and individualised care.

We saw care plans were subject to regular review when people's needs changed. Annual reviews also took place where people's comments and experiences were used to make changes to care and support plans. As part of these reviews, care rotas and visit times were discussed to help improve people's satisfaction with the service.

Daily care logs provided evidence of the care and support provided. Whilst these were generally well completed, they were very task based and could be more person centred. Hand writing quality was variable and one person complained to us that they could not always read the writing.

People provided mixed feedback about the timing of calls. Most people said carers arrived on time. One person said, "Yes always on time." A second person said, "No issues with timing." However another person told us, "It would be better I knew what time they were supposed to come. It can be between 5pm and 8pm at weekends." On reviewing records we saw that most calls took place at roughly the same time each day, albeit with some variation. We saw electronic call monitoring was being used to scrutinise and improve the timeliness of staff further. Some people we spoke with said they were not happy with the times staff visited. Whilst we saw the agreed call times were in place within people's risk assessment document, these were often not reviewed when the care plan was updated. We discussed with the registered manager the need to have a clear call time agreement so people knew when to expect staff.

At the last inspection in November 2016 one of the most serious concerns we identified was staff significantly cutting short visit times, rushing and not completing all required care tasks. Introduction of electronic call monitoring, provision of travel time and increased monitoring of care workers practice had

led to improvements in this area. Most people now said staff stayed for roughly the required amount of time and completed all tasks. A few people still said care workers were rushed; however overall, feedback was much improved in this area.

At the last inspection we found a low level of satisfaction with the service. We saw the service had made a genuine effort to address people's concerns. This was reflected in feedback which showed increased satisfaction with the service. One person said, "It is nice to co-operate with the company, they listen to me, they talk and try to sort things out. I have no complaints or faults to complain about." Another person said, "I am ok, no complaints at the moment. A third person told us, "They came down to see me when I complained, three people from the office, they are trying." A relative said, "We did have issues, the company initially did not listen, they then listened and sorted it out for us." However another person commented, "I keep my mouth shut, not happy, it does upset me about the timing, I now do not bother to complain as they do not listen." A second person said, "You can ring and complain [about time keeping] but they don't always get back to you." This showed there was still some work to be done to further improve people's sentiment about the service.

We saw where complaints and concerns had been received these were categorised according to their severity and if were a formal complaint or a concern. The registered manager had devised a flow chart to indicate what actions should be taken and we saw this was adhered to. For example, minor concerns were documented and the person contacted to discuss and resolve their concerns. If this did not resolve the issue, the concern was escalated to a more serious concern, fully investigated and the complainant contacted with the investigation results by letter. We saw the number of formal complaints had reduced considerably since our last inspection, with only three formal complaints being investigated since the start of 2017. We saw once complaints were actioned and investigations concluded, the service followed this with a quality assurance phone call to the complainant or a spot check visit to ensure the concern was fully resolved.

Requires Improvement

Is the service well-led?

Our findings

We found the service had notified us of the required statutory notification such as allegations of abuse. This helped us monitor events within the service.

A registered manager was in place. They were supported by care co-ordinators and a quality manager. We found the management team to practice an open and honest culture and be committed to continuous improvement of the service. Staff spoke positively about the management team and said they were approachable. Comments included, "The management team are good and supportive", "I think staff are happier. Management listen to us", "Any problems, I can speak to [registered manager] and the office. I'm happy", "I'm happier now; they have improved," and, "Any problems, they'll support me then and there."

Most staff we spoke with said improvements had been made to the service and they felt better care was now being provided. One staff member who completed spot checks and monitored people's sentiment towards the company said, "There has been a reduction in the number of complaints. We have a good staff team at the moment and staff are better organised." Some staff said they felt further improvements needed to be made, such as communication between care staff and the office regarding any sudden additions to rotas and informing people if the care worker was going to be late. Overall, staff morale was good.

At the last inspection we identified a number concerns around staffing levels, care visits being cut short and people not getting the required care and support. Feedback about the quality of the service was poor. At this inspection we found significant improvements had been made. There were now enough staff to ensure a reliable service and rotas had been changed to give care staff more time to spend with people. Feedback about the quality of the service showed that whilst some people were still unhappy with timeliness, satisfaction in the service had improved. Comments included, "They have changed for the better, they listen more", "I am really happy with the company," and, "No problem at all, we are really happy with the company." Some people we spoke with still had concerns about the service. For example, one person said, "Not happy with them, they do not listen." We concluded further engagement was needed with some people to address their remaining issues.

Systems had been put in place to continuously improve the service. This included better rotas, enhanced staff training and new medicine records. These areas were being regularly audited by the registered manager to ensure continuous improvement. For example, rotas were audited to ensure they were realistic and people and staff were asked for feedback on how the new medicine system was operating. A quality manager was employed who spent most of their time conducting audits. Spot checks of staff practice were used to drive improvements in staff practice, as well as ensuring care documentation and medicine records in people's homes were up-to-date and accurate. Following these checks, actions were put in place to address any shortfalls.

Daily logs of care and medicines records were now brought back to the office on a regular basis and subject to regular audit. We saw these were mostly effective in identifying issues to drive improvement. However, some of these required further improvement. For example, we saw improvements were required to the

auditing process for complaints which currently served as a calculation of monthly totals rather than an analysis of trends to drive improvements. We also saw where one person's daily notes had been audited in February 2017 and had not picked up where staff had not stayed for the required length of time or had not recorded arrival or departure times. Daily notes were required to be returned to the office where possible on a monthly basis for audit. However, we saw one person who had commenced the service in August 2016 had not had any audit of their daily notes done. This person was not receiving electronic call monitoring (ECM) so we were concerned how the service knew if staff were staying for the correct amount of time. We spoke with the registered manager who showed us a spreadsheet which showed this person's notes and care plan had been identified as requiring urgent audit.

Since our last inspection, the service had introduced a new role of 'lead carer' to each area to ensure specific tasks were completed such as documentation. Staff we spoke with told us this had improved the quality of information kept at people's properties. However we found improvements were still required to some documentation around medicines management. In addition, we saw where one person at nutritional risk had fluid charts in place and only basic information was recorded rather than the actual amount consumed. This meant we were not able to establish if the person was consuming adequate amounts of fluid daily. We spoke with the quality manager and registered manager who agreed this needed to be improved.

This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities') 2014 Regulations.

The service had recently implemented electronic call monitoring (ECM). Roughly 50% of people had consented to this system being used in their homes. We saw audits were completed on a weekly basis by the registered manager, analysing whether staff had arrive on time and stayed for the correct amount of time. The findings of these audits were used to make changes to rotas and if trends were identified with particular staff members, supervision or disciplinary action was taken. This demonstrated a service committed to further improvement performance. Staff provided good feedback about ECM However we saw there were gaps in the data where staff had forgotten to log in and out. The registered manager told us they were trying to address this with staff. One relative also told us this was a concern saying, "They have a new system to ring when they get in and out, some do the ringing, some do not ring in and out."

The service listened to people and sought their feedback to drive improvement. People's feedback was gained through telephone interviews, during spot checks and in review meetings. Any areas for improvement were noted and action plans produced to address the issues raised. For example, following any complaints about staff, spot check and supervision processes would be followed. People were also asked for their feedback through regular surveys. We saw these had been adapted to specifically look at areas of concern from the previous inspection such as call times and medicine records. This showed a dedication to addressing the issues we previously identified.

Feedback from service users through the recent survey showed much improved satisfaction levels, consistent with our findings of an improving service. Overall feedback was 85% positive and plans were put in place to address the remaining negative feedback. One comment said, "Family feel safer now to know [staff] have been checking books and MAR charts."

Staff meetings were held and we saw improvement topics were discussed as well as service user feedback and spot checks. This evidenced the service was committed to continuous improvement. Staff we spoke with told us staff meetings were held at least monthly with team meetings held in between. They said these were a good opportunity to voice and discuss any concerns as well as receiving updates and information from the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2010Good Governance (1 (2c) A complete and accurate record of the care of each service user was not always provided.