Fairmeadows Home Care Limited

Fairmeadows Home Care Office G05

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This inspection took place on 19 and 20 January 2016 and was announced because we wanted to ensure there would be someone at the service office when we called.

Fairmeadows Home Care is based in Ashington, Northumberland. It provides domiciliary care to people across the south east of Northumberland. At the time of the inspection the service was supporting 40 people.

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since November 2011. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The registered manager was also a director of the company.

People told us they felt safe when receiving care. They told us they trusted the care workers who supported them and looked forward to them visiting. Staff told us they had received training in relation to safeguarding adults and would report any concerns to a senior member of staff. The provider had dealt with three safeguarding issues in the last 12 months and had involved adult safeguarding services appropriately, although they had failed to notify the CQC of the incidents.

Processes were in place to recruit staff and to carry out checks to ensure they were suitably experienced to support people with their personal care needs. Some staff had joined the service with existing Disclosure and Baring Service (DBS) checks. The manager told us risk assessments, to ensure that it was appropriate to accept previously issues DBS certificates, were undertaken. However, these assessments were not formally recorded. People told us that staff generally attended appointments on time, although there were occasional late calls. People told us there had been missed calls in the past but these were not regular events.

Staff told us there was always a senior care worker on call to provide information and advice. Senior care workers could also call on managers or directors for advice and support, if necessary. Senior care workers on call had access to care plans and information on line to deal with any questions or queries.

There were no clear records of the medicines that care staff were administering or supporting people to take. There were no care plans for "as required" medicines, meaning there were no instructions for care staff about how and when these medicines should be given. There were no body maps or visual indications of where creams or topical medicines should be applied. Medicine records were in the form of a daily log making it difficult to see how often medicines had been given or omitted.

People told us they felt that staff had the right skills to support their care. Staff told us they had received

sufficient training to carry out their roles. The provider was moving to an on line training system which would support the regular review and updating of staff training. Staff told us they received regular supervision and we saw documents that supported this. The manager told us that only a small number of staff had been with the service more than a year and he had not yet arranged annual appraisals.

The Care Quality Commission (CQC) is required by law to monitor the operation of the Mental Capacity Act 2005 (MCA) including the Deprivation of Liberty Safeguards (DoLS), and to report on what we find. MCA is a law that protects and supports people who do not have ability to make their own decisions and to ensure decisions are made in their 'best interests'. The manager was not aware of anyone supported by the service who was subject to an order under the Court of Protection (CoP). Questions about CoP orders and Power of Attorney were not routinely included in the assessment process. We have made a recommendation about this.

People told us that they found staff caring and supportive. We observed there to be good relationships between people and the care workers who supported them. They said their privacy and dignity was respected during the delivery of personal care and support. People were also supported to maintain their well-being, as staff worked with district nurses or would support people to contact their general practitioner, when necessary.

People's care needs were assessed, although a formal record of the assessment undertaken was not always available in people's records. Care plans detailing the type of support people should receive where contained within care records in people's homes. Staff told us there was sufficient information for them to carry out care effectively and people told us staff often referred to the plans when they visited. Care plans did not always have a date to indicate a maximum time before they should be reviewed. The provider had a complaints procedure in place. There had been no formal complaints within the last 12 months. People told us they had not raised any recent complaints and any issues or concerns they had raised were dealt with.

Senior care workers undertook regular spots checks on care workers to ensure they were providing appropriate levels of care. Wider audit and checking processes were not always in place, particularly around the safe administration of medicines. Records related to assessments of people's needs or risk assessments for staff were not routinely recorded. Questionnaires had been sent to people to ascertain their views of the service. Indications from the questionnaires were that people were positive about the service. Staff told us there were regular meetings and information was provided to ensure they were up to date about any changes in systems. Daily records were up to date and contained good details. The provider had failed to notify the CQC of significant events related to the running of the service.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to safe care and treatment and good governance. We also found a breach of the Health and Social Care Act 2008 (Registration) Regulations 2009, in that the provider had failed to notify us of incidents they are legally required to do so. You can see what action we told the provider to take at the back of the full version of the report.

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.

Medicines were not administered safely and effectively. Records related to the safe handling of medicines were not detailed or clear in relation to the range of medicines given to people. Staff did not always use protective equipment when supporting people with their personal care.

Effective checks on staff being employed by the service were undertaken, although records of these checks were not always available. People told us there were enough staff and appointments were rarely missed.

People told us they felt safe when staff supported them with care needs. Staff told us they had received training in relation to safeguarding adults and would report any concerns. Risk assessments were in place regarding the delivery of care in people's own homes.

Is the service effective?

Requires Improvement

The service was not always effective.

The provider told us that no one receiving care or support had any restrictions on their liberty through the Court of Protection (CoP) in line with the Mental Capacity Act 2005 (MCA). The provider did not routinely include in their assessments whether there were any restrictions under the CoP or whether any Power of Attorney agreements were in place.

People told us they felt staff had the right skills to support their care. Staff confirmed they had access to training and the provider had a system in place to ensure this was up to date. Staff received regular supervision.

People were asked to consent to care on a daily basis, although care plans were not routinely signed to say people agreed with the identified care. People told us they were supported to access sufficient food and drink.

Is the service caring?

Good

The service was caring.

People told us they were happy with the care they received and were well supported by staff. They told us they looked forward to care workers visiting them and viewed them as friends as well as helpers. People told us staff helped maintain their dignity during the delivery of care.

People's wellbeing was effectively monitored and staff told us they would support people to contact general practitioners or other health professionals, if necessary. Staff were aware of the need to maintain confidentiality.

Is the service responsive?

Good

The service was responsive.

Assessments of people's needs had been undertaken and care plans were in place. Records of the assessments were not always available. People told us they could make changes to their care packages if they needed to. A new scheduling tool had been put in place to improve care delivery.

Staff were aware of the issues and risks related to social isolation and that they may be the main contact people had with the outside community. People told us they valued the contact they had with care staff.

The provider had a complaints policy, although no formal complaints had been received in the last 12 months. People told us they had not made any formal complaints and any concerns were dealt with quickly.

Is the service well-led?

Requires Improvement

The service was not always well led.

The provider had failed to notify the CQC of safeguarding events in the service as they are legally required to do so. Audits of the service had not identified issues with medicines management and effective risk assessments for staff recruitment not being in place. People confirmed that spot checks were regularly undertaken by senior care workers.

Staff talked positively about the support they received from the manager and other senior staff.

There were regular staff meetings. Questionnaires had been sent to people who used the service to ascertain their views. Daily

records contained good detail.

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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 19 and 20 January 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 someone would be in.

The inspection team consisted of an adult social care inspector.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed information we held about the provider, in particular notifications about incidents, accidents, safeguarding matters and any deaths. We contacted the local Healthwatch group, the local authority contracts team, the local authority safeguarding adults team and the local Clinical Commissioning Group. We used their comments to support our planning of the inspection.

We visited six people in their own homes to obtain their views on the care and support they received and also spoke with two relatives. We witnessed interactions between people and their care workers during these home visits. We spoke with two care workers and a senior care worker. We also spoke with the registered manager, office manager, scheduling manager and a director of the company. At the provider's office base staff showed and explained electronic recording systems used by the service.

We reviewed a range of documents and records including; five care records for people who used the service, including information about how they were supported with their medicines. We also examined five records

of staff employed by the service, duty rotas, complaints records, accidents and incident records, records of staff meetings and a range of other quality audits and management records.

Requires Improvement

Is the service safe?

Our findings

People told us they were supported with their medicines as part of their care packages. They told us care workers would support them in various ways, including prompting them to take tablets and administering tablets from dosette boxes or individual boxes provided by local pharmacies.

We checked how medicines were handled when we visited people in their homes. We found that not everyone's care records contained a list of the tablets they were taking on a regular basis. Care workers were completing daily records with the phrases such as, "Dosette box given", without any means of recording that all the required tablets were available. Where people did have a list of medicines this was not always complete or did not contain sufficient information to be an effective checking device. Some records did not contain information of dosages, the route medicines should be given or the frequency. One person's medicines had been set out for the week by a relative rather than a pharmacist. There was no list of what medicines had been placed in the medicines dispensing device and no means for care workers to check they were giving the person the correct medicines. This meant people may receive the wrong medicines because there were no clear records or instructions for care staff to follow when dealing with medicines.

Some people were receiving "as required" medicines as part of their medicines support. "As required" medicines are those given only when needed, such as for pain relief. Care records did not contain specific details of these medicines, what conditions they should be used for, how care staff would know when they were required, the allowed frequency, or the maximum dosage allowed in a given period. Where people were being supported with creams or medicine patches there were no body maps or visual indications as to where these should be applied. Because medicine records were written in the form of a daily log, rather than on a medicines administration record (MAR), it was difficult to check how much and how frequently "as required" medicines had been given. This meant there was a danger of people receiving the wrong or an excessive dose of medicines because records were not always clear.

Where people were being supported with medicines a risk assessment had been undertaken. This assessment did not always reflect the care plan or the care being given. For example, in one care record the medicines risk assessment stated the person was able to deal with their own medicines. However, their care plan stated that care staff were required to administer the person's medicines. We spoke to the person concerned, who confirmed that care staff administered medicines for them to take. This meant the risk assessment did not reflect the care being delivered and did not address the true risks.

We noted from care records that one person frequently declined their medicines when offered them by the care workers. The person had capacity to make decisions, such as whether to take medicines or not. However, there were no instructions or information in the person's care plan as to when or if care staff should alert the person's general practitioner, if they declined medicines over a long period. This meant people's health may be put at risk because health professionals may not be alerted to people not taking prescribed medicines over a sustained period.

We spoke to the manager about supporting people with their medicines. He told us there had been

discussions with social workers and other professionals about how to record the administration of medicines. He understood because medicines were identified on the dosette boxes that this was sufficient information and was not aware of the need to have a permanent record of the medicines given. He said he would look at introducing a revised medicines system for the service. Following the inspection the manager wrote to us to confirm that a review of medicines documentation and recording had taken place.

Staff told us they had easy access to gloves to be used when supporting people with their personal care. They said they did not use aprons during their care tasks. One relative told us they had observed staff did not always wear gloves and felt that care staff did not wash their hands frequently enough. Staff told us they had completed infection control training but this was predominantly on line. We noted from care records, and talking with people about their care that a frequent support task for care staff was to empty commodes or urine bottles. This meant that, because aprons were not used, there was a risk of cross infections and contamination of care workers uniforms through splashing from the emptying and cleaning process. We spoke with the manager about this. He said he had not felt that aprons were necessary, but understood the risk of contamination and would look to provide additional equipment. He said he would also remind staff about good hand hygiene during staff meetings. Following the inspection the manager wrote to us saying that staff had been reminded about the need to use aprons during personal care and that supplies of aprons had been provided in people's homes.

This was a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 Regulation 12. Safe care and treatment.

The manager told us that the service had expanded rapidly recently and so a number of new staff had been recruited. The office manager demonstrated a new computerised recruitment and staffing system they had recently introduced. The system took them through the recruitment processes and offered prompts about taking up references and ensuring Disclosure and Baring Service (DBS) checks were made. DBS checks ensure staff working at the service have not been subject to any actions that would bar them from working with elderly or vulnerable people. We examined personnel records for staff and saw that a proper recruitment process had been followed, including a full application form completed, interview and identity checks.

Some staff had joined the service from other social care providers and had a current DBS. The manager told us checks had been made using the DBS update services which allows existing DBS records to be checked. However, there was no record of these checks taking place. Similarly were an item had been raised through DBS, often for minor offences when staff were younger, there was no recorded risk assessment. The manager told us this was considered at interview but not formally recorded. For some people verbal references were indicated as having been obtained. The provider's own recruitment policy advised that such references should be noted in writing. The office manager told us this was usually done but could not find all the records of verbal references. This meant checks and risk assessments linked to staff recruitment, whilst taking place, were not always recorded effectively.

Staff told us they felt there were now enough staff in the service to deliver the care required. They told us there had been a period where it had been more difficult, but in recent months things had improved and staffing levels had increased. People and their relatives told us there had been one or two missed or late appointments in the past but these had significantly reduced more recently. People told us occasionally an unfamiliar care worker attended because of sickness or absence. The manager told us the service was not currently taking on any additional packages of care to allow systems and staffing to settle down and ensure they could deliver the current demand before developing the service further.

People told us they felt safe when receiving care. Comments included, "I definitely feel safe with the carers, yes" and "I always feel safe when they are here." One relative told us, "I'm often here anyway, but I feel my parents would be safe if I wasn't here." Staff told us they had received training in relation to safeguarding adults. They were able to describe what action they would take if they had concerns about people's safety or if they were at risk of abuse. The service had dealt with three potential safeguarding issues within the last 12 months. We saw that a record had been made of the issues and the safeguarding adults team alerted. Where the issue required investigation by the service this had been undertaken. This meant people were protected against the risk of potential abuse or harm.

People's care records contained a risk assessment document. The assessment looked at issues related to the delivery of care, mobilisation and moving and handling. The risk assessment considered the likelihood and the severity of a risk. Risk assessments tended to cover common issues and it was not always possible to determine how they fitted with people's personal circumstances. We spoke with the manager about this who said he would consider how to make risk assessments more individual.

Staff told us there was always a senior care worker available on call during working hours. They said they could call for advice anytime and that the call was always answered or returned. A senior care worker told us that they could generally deal with most issues, but they could contact the manager or a senior person in the organisation, if they also required additional support or advice. This meant there was an effective system in place to support workers and manage potential risks or emergencies.

Requires Improvement

Is the service effective?

Our findings

People told us that care staff had the right skills to support them. Comments included, "All the carers know what to do"; "I get different ones coming sometimes but they all seem to know what they have to do" and "All the girls are nice; they are lovely. They all know what to do."

The office manager showed us the new training recording system the service had recently introduced and told us they were currently trying to transfer information from the old system onto this new system, to make it as up to date as possible. The new system would not only record current training, but alert the user when training required updating or refreshing. Staff told us they had received a range of training, including moving and handling, infection control, safeguarding and food hygiene. Records confirmed this. They told us they felt they had access to sufficient training to carry out their roles.

The manager told us the service now used an on line training company to provide training. This meant care staff could access training at any time and the service could monitor progress with training. Staff said the online training was useful, but some practical training could be helpful. The manager told us that he was looking at face to face training for practical issues such as moving and handling. Staff told us that where they were supporting people with specific health needs, such as with catheter care, they worked with district nurses or other community staff, who demonstrated appropriate procedures for them to follow.

Staff told us they had regular supervision sessions and records confirmed these took place. Staff said they could raise any issues during supervisions, but they could also pop into the office and seek advice or support at any time.
The manager told us there had been a considerable influx of new staff. Only a small number of staff had been in the service over a year. He said that for this reason yearly appraisals had not been undertaken, but the concentration had been on regular supervision. He told us that alongside the updating of the training system a proper system for supervision and appraisals would be developed. This meant appropriate systems for training and supervision were in place but that appraisals were yet to be arranged or undertaken.

People we spoke with told us that communication with and from the provider's main office was generally good. They told us the phone was quickly answered and any queries dealt with appropriately. They told us there had been some initial teething problems but these seemed to have been sorted out now. Where care workers were held up, due to traffic or weather problems, then the office would contact them to advise them that the call was likely to be late.

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. The application procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA and whether any conditions on authorisations to deprive a person of their liberty were being met.

The manager told us no one currently being supported by the service was subject to any restrictions on their freedom or was under an order from the Court of Protection. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time they need to be made, because they may lack capacity to do so. He told us he was not aware if anyone being supported by the service had a Power of Attorney (PoA) agreement in place. Power of Attorney is a legal process where friends or relatives have legal powers to make decisions on people's behalf, where they are unable to make those decisions at the time. He said these areas were not routinely covered by their initial assessment, but the process would be updated to ensure they were covered in the future.

We recommend the provider ascertains and records information related to Court of Protection orders or Power of Attorney agreements in force, as part of their assessment process.

Staff described how they obtained consent on a day to day basis and checked with people that they were happy with the care and support being offered. One care worker told us, "You talk to them all the time. You ask them if they are okay with things. You always check." One person told us, "They always ask permission before they do something." Care plans contained formal consent agreements regarding support with medicines. However, other care records had not been formally signed by people, to indicate they were happy with the plans. The manager told us that they had done this previously, but this had been missed off the new care plan format and would ensure this was reinstated. People told us they were happy with their care plans and with their care delivery. One person told us, "All the care is as I like it. I have two carers and they are absolutely excellent." This meant care workers sought people's consent prior to delivering care but formal consent was not always recorded.

People were supported to maintain their health and wellbeing. Records showed people were supported to contact general practitioners or other health professionals, as and when necessary. Staff told us they worked jointly with district nurses or other community staff where people had specific health needs.

People told us that care workers supported them in ensuring they had plenty to eat and drink. Care plans contained information on how care staff were to support people, through the preparation of meals and drinks. People we spoke with told us staff always made them a drink and would prepare breakfast or other meals. They said that where care staff were not immediately returning, such as over a lunchtime, they would prepare sandwiches in advance, to ensure they had something to eat. One person told us, "They leave me a sandwich for lunch. I tell them what I would like to have." This meant staff supported people to maintain an effective intake of food and drink.

Good

Is the service caring?

Our findings

People told us staff were caring and supportive. Comments from people included, "The care workers are very good. Very friendly and very pleasant"; "All the girls are nice. They are lovely"; "Overall I'm happy with the care. They are very nice. It's good at the moment. Very pleasant"; "Very thorough, kind and gentle." One relative told us, "They are really wonderful. They support me as well. Nothing is too much trouble."

People told us they had a good relationship with the care staff who supported them. One person described the care workers as being like family members and said they enjoyed them coming and looked forward to the visits. People said they were involved in their care and that care staff not only did things for them but supported them to do things for themselves. One relative told us, "They don't just follow the care plan. They take note of what I say as well." A person told us, "They are excellent and if I need anything extra I just ask."

We noted from records that staff had supported people to gain comfort from their partners, by facilitating opportunities for them to hold hands and reassure each other when distressed.

People and relatives told us they had been involved in the development of care plans. Relatives told us they had been able to offer suggestions or revise care plans and that these changes had been incorporated into the eventual final plan. Some people told us that it could take a couple of weeks to get a final plan into place, but that staff knew what to do. One relative told us, "It took a while but we were emailed a copy of the plan. We tweaked it with a covering note and all the changes did appear in the care plan." The manager told us that the service had expanded quite considerably in recent months and that this had impacted on the service's ability to fully involve people. He said that as new planning systems were brought in there would be an improved system to ensure that all aspects of the care planning process were covered.

People told us they had enough information about the care they received and said if there were any changes or issues they were contacted by the service office. Information about how to contact the office, or the out of hours system, were contained within people's care records. People commented they were not aware of regular care reviews, but also stated that they had only been with the company a number of months. They said if their care needs changed then they could speak to the service. One person told us they would like a later night time call. They said this was being looked at, but it was taking a time to organise the staffing to cover the requested later time. This meant people could ask for additional support as their needs changed.

The manager told us there was currently no one using the service who was being supported by an advocate. An advocate is an independent person who supports people to make decisions about their life or represents their views when they are unable to do so themselves. He said that most people using the service had relatives who also supported them. He told us that relatives regularly contacted the office, if they had any issues or concerns. People we spoke with confirmed their relative would help with contacting the service, if they needed to.

Staff understood about the need to maintain confidentiality. They talked about being discrete when supporting people and not getting into conversations about other people they were supporting. They said

they if they took a call whilst they were in a person's house, possibly asking them to add another call to their list, they would speak in general terms and not mention people's names or addresses. We saw that the issue of maintaining confidentiality was covered in staff meeting minutes. This meant staff understood the need to safeguard people's personal information.

People told us that their privacy and dignity were respected and supported by the care staff. One relative told us, "They are very good. They deal with things sensitively and don't make (relative) embarrassed at all." One person, talking about being supported by male care staff told us, "If they are doing something good for you that is the main thing. At my age I'm not embarrassed about anything." Another person told us, "They try and make it as dignified as possible. No problems there. I'm not shy and the girls are okay about it." Staff were aware of the need to maintain people's privacy and dignity. They talked about ensuring people were covered during the delivery of personal care and making sure that doors and curtains were closed. This meant staff maintained people's dignity when supporting them with care.

Good

Is the service responsive?

Our findings

The manager told us that the service had grown rapidly in the last few months and that, whilst in the initial stages there had been occasions where calls had been missed things were now settling down and the service was able to respond to requests appropriately and in good time.

People told us that care staff were responsive to their needs. Comments included, " They always ask me if there is anything else that needs doing"; "I tell them if I need anything extra and they are very obliging" and "They sort things out there and then. They try and make things more feasible for people." People also told us that they did not feel rushed with their care and that care workers would stay as long as was needed. Comments here included, "They turn up on time and often stay that bit longer. There always seems like there is plenty of time. They don't make it rushed" and "I don't feel rushed when they help me." One person told us that sometimes care workers did leave slightly early to get to their next appointment.

We saw people had care plans detailing the care they should receive and the time that care should be delivered. Plans contained information important for care delivery such as ensuring people were asked about the type of toiletries they wished to use and clear instructions about how to move a person safely when helping them out of bed. Where people had specific moving and handling needs then a manual handling plan was also in place. This plan detailed how many care workers were required for particular support and whether people required the use of equipment, such as a hoist or slide sheet when in bed. There were no clear records of how assessments had been undertaken. The manager told us that assessments were undertaken but the details were not always recorded and stored in people's care files. This meant that records showing a full and proper assessment of people's needs were not always available.

Care plans included some information about the person's background and circumstances, including activities they liked to take part in. It also included information such as a person having a hearing loss which care workers needed to be aware of when delivering care or talking to them about their care. Other information included if family members did people's shopping or laundry. This meant care records contained information that allowed care staff to deliver person centred care.

People and their relatives told us that care packages could be reviewed and altered as needs required. Relatives told us that additional visits could be programmed in and these were accommodated, often at short notice. One relative told us, "A care worker had left a note suggesting an increase in time might be helpful. They were very helpful and put the calls in very quickly." The manager said that most of the current packages had only been running a number of months, so full formal reviews had not taken place, but any additions or changes in care would be considered and incorporated. People's risk assessments indicated these should be reviewed at least six monthly, but care plans did not always indicate when full reviews should be undertaken.

Staff we spoke with told us there was sufficient information in the care plans for them to be clear about the type and levels of care that was required. People told us that when new or unfamiliar care workers arrived at their homes they read the care plan, as well as asking them about their care.

The service had recently purchased a new scheduling programme to improve the organisation of appointments. A scheduling manager had also been appointed to manage the new system. The scheduling manager demonstrated the new programme. He told us the service had been divided into teams to give a more focussed and responsive service and cut down on the distance that care workers were required to travel. He told us it had taken some time to get the programme up and running and fully attune it to the required work, but it seemed to be working well now. The programme contained details about individuals and their care needs, including their preferences to assist with scheduling. For example, a person who had indicated they did not want male staff to assist them could not be scheduled to have visits from male care staff. The system also contained important information, such as relative's contact details. This information could be accessed by the senior on duty, which helped if they were contacted by a care worker who was unsure about any aspect of a person's care.

The programme also produced duty rotas for care workers, which they could access on line. The system also allowed texts or messages to be sent to care workers, if there were any changes in a person's care details, such as a call being cancelled or an additional call was required. The scheduling manager told us that the eventual aim was to set up a call in system, when care workers called from a landline to say they had arrived at a person's home and then called again when leaving. This would help in monitoring any missed or late calls and also the time spent delivering care. This meant the provider had a system to respond to the changing needs of people and deliver a responsive service.

Staff were aware of the potential for social isolation of people who they visited and were aware they may be the only visitor they received that day. People told us they looked forward to the carers coming to help them. One person told us, "I prefer people coming in to keep an eye on me. It is also someone to talk to." A relative told us, "It's a reassurance to know there is someone coming in."

The provider had a complaints policy in place. The manager told us there had been no formal complaints within the last 12 months. People we spoke with told us that they had not raised any formal complaints. Comments included, "I've not had any reason to complain" and "Overall I'm very happy. No complaints." People and their relatives told us that where they had raised concerns or queries these were generally dealt with appropriately and quickly, including the manager visiting to discuss any issues. This meant the provider responded to complaints or concerns.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed he had been formally registered with the Commission since November 2011. He was present on both the days we visited the office base and assisted with the inspection.

We found that the provider had failed to notify the CQC of three safeguarding issues within the last 12 months. Providers are required by law to notify the CQC of significant events; including safeguarding events, deaths and serious injuries. This is so we can maintain an awareness of how the service is operating and be aware of any concerning information. We spoke with the registered manager about this. He acknowledged that the notifications had not been submitted and said this had been an oversight, as he was not aware safeguarding issues were required to be notified.

This was breach of the Health and Social Care Act 2008 (Registration) Regulations 2009. Regulation 18. Notification of other incidents.

The provider had also failed to maintain effective records related to staff recruitment, in that risk assessments related DBS checks and the taking up of verbal references were not always recorded. Records of assessments of care needs were not always available in people's care records to demonstrate that an effective review process had been followed. Proper management checks had not taken place to ensure that the administration and support of medicines in people's home was in line with regulations and the recommendations of the Royal Pharmaceutical Society. The manager told us that a note was normally made of any verbal references. But these could not be found at the current time. He also told us that risk assessments had taken place, in relation to DBS checks, but had not been formally recorded. With regards to medicines, he said he was not aware of the need to have a permanent record of the medicines given. He said he would look at introducing a revised medicines system for the service.

This meant proper management and monitoring systems were not in place to ensure the effective running and oversight of the service.

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

The manager told us that the service had expanded rapidly in the last few months. He said the majority of the work undertaken were private packages, where people funded their own care. He also told us that the service had recently entered into a subcontract agreement with a larger provider. This meant they had taken on a number of existing packages, as well as new work. He said he had recognised that this increase in work needed to have a more extensive and robust management team in place. He said the service now employed a specific manager to oversee the finances of the service, including billing, invoicing and staff wages. Additionally, an office manager had been employed to oversee all training, supervisions and appraisals, along with recruitment and a scheduling manager to support the new scheduling software. He said that the service had now been divided into localities with identified teams and a senior care worker for each of these

localities. He said this helped to improve the timeliness and consistency of provision. This meant the provider was responding to the increasing management demands of a developing service.

Staff told us that they felt supported by the management. They said that if they had any problems they could call the office or simply pop in. During our inspection a number of staff came to the office for additional equipment or to hand time sheets in and sat talking with one of the managers. Comments from staff included, "The managers are really good; quite approachable"; "I don't have any problems with him; he is very approachable" and "The manager is a good manager. The best manager I've had for a long time."

Staff told us that in the recent past the service had been busy but that more staff had been recruited and matters had calmed down. They told us they were happy in their work and felt there was a good staff team at the service. Comments from staff included, "We are close. It's a good staff team. We help each other a lot; will cover calls and things" and "We all work together well." Staff said they enjoyed their work and got satisfaction from supporting people. Comments here included, "I enjoy it very much. You are giving something back to people who need your help" and "I love my job. Going out to visit and helping them out and talking to them. It is nice to see when they have a smile on their face."

The provider had circulated a questionnaire to people who used the service in September 2015, to solicit their views and opinions of the service. 19 questionnaires had been returned. The questionnaires covered areas such as: "Were staff respectful?"; "Were staff professional in their approach?"; "Did people feel safe when care was being provided?" and "Were people satisfied with the service overall?" Of the 19 returned questionnaires 15 indicated they agreed or strongly agreed with the statements that they were happy with the service. Some people had included comments about the service. Comments included, "All carers I have had in my home have all been very professional and polite. Very respectful, kind and considerate. They have gone above and beyond the call of duty" and "I am very happy with the carers I have as they are very friendly to me and I think that goes a very long way as you need friendly and trust worthy carers."

Two of the questionnaires raised specific concerns. We asked the manager what action had been taken in relation to these issues. He told us they had been addressed individually and the problems highlighted dealt with. We asked if there was a wider action plan linked to the questionnaire. He said there had not been time recently to look at this, but it would be something for the management to look at. This meant that people had been asked their opinion of the service and action taken to address specific concerns.

Staff told us there were regular spot check visits by senior care workers to ascertain if they were delivering care to an appropriate standard. We saw copies of spot check assessment forms. The checks covered areas such as: "Did the care worker arrive on time?"; "Were they wearing uniform?"; "Did they record care properly?" and "Did they ask the person if they were satisfied?" We noted that where there were any issues then action was taken. People we visited told us that senior care workers did call to check on the care workers whilst they were providing care and support. This meant there was a system in place to monitor the direct work of care staff employed by the service.

Staff told us there were regular staff meetings when they could raise issues or discuss any concerns that they had. We saw the minutes of the latest staff meeting, which covered several areas about maintaining quality in the service. The minutes highlighted the excellent service that had been delivered over the Christmas period, up held the fact that calls should not be rushed, reminded staff that records needed to be completed accurately and fully and underlined the need to maintain confidentiality. Staff were reminded it was important to feed back any problems or concerns, so these could be tackled early and also requested "open and honest" feedback to help improve systems. This meant there were systems in place for staff to influence the running of the service.

Daily records completed by care staff were up to date and contained good information about the care they had provided. Records highlighted people's mood or any issues that it was important future care workers were aware of.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Care and treatment was not provided in a safe way because medicines were not always managed effectively and risks associated with controlling infection were not always managed. Reg 12(1)(2)(g)(h)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Systems and processes were not in place to assess, monitor and improve the quality and safety of the services provided. Reg 17(1)(2)(a)(b)(c)(d)

This section is primarily information for the provider

Enforcement actions

The table below shows where regulations were not being met and we have taken enforcement action.

Regulated activity	Regulation
Personal care	Regulation 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify the CQC of events they are legally obliged to do so.

The enforcement action we took:

FPN