Gateshead Council

Domiciliary Care & START Service. Gateshead Council

Inspection report

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Date of inspection visit:
02 June 2016
07 June 2016
08 June 2016
09 June 2016
10 June 2016

Date of publication:
20 July 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 2 and 7 June 2016 and was announced. We also made phone calls to staff, people and their relatives on 8, 9 and 10 June 2016.

We last inspected this service in February 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

Domiciliary Care and Start is a domiciliary care service provided by Gateshead Council that provides personal care to people in their own homes. At the time of this inspection, the service was providing care to approximately 260 people in the Gateshead area. The service is broken down into four separate areas; long term domiciliary care, short term re-ablement services, extra care housing and a rapid response function to provide assistance to people in crisis.

The service had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons.' Registered persons have a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People were kept safe from harm. Staff received regular safeguarding training and were aware of the different types of abuse people might experience. Staff were aware of their responsibility for recognising and reporting signs of abuse. People told us they felt safe.

Possible risks to the health and safety of people using the service were assessed. Where risks were identified, actions were taken to minimise these whilst also taking into account the person's wishes.

Robust systems were in place for the recruitment of new staff members. Checks were completed to establish whether potential staff members had criminal records, to determine their right to work in the UK and references were sought to verify the information supplied on their application forms.

People were assisted to take their medicines safely by staff who had been appropriately trained. Regular checks were completed of Medicines Administration Records (MAR) to check people were receiving their medicines as prescribed.

Staff were given the appropriate training and support they required to work effectively. Staff spoke highly of the training they received and the provider encouraged and supported staff to undertake additional qualifications relevant to their roles.

People were asked to give their written consent to their plan of care and staff were aware of the importance of offering people choice and respecting their wishes. Care plans were reviewed on a regular basis and people told us that when changes were requested these were made promptly.

Care workers were described as kind and caring and people told us they were treated with respect.

An external professional raised concerns with us about staff members understanding of the Mental Capacity Act (MCA). We highlighted these concerns to the registered manager who took immediate action following the inspection to ensure people using the service were not at risk of harm.

People told us they were happy with the management of the service and knew who to contact should they have any concerns. Staff we spoke with felt supported by the management and told us they were generally able to access support when they required it.

The provider had a range of systems in place for checking the quality of the service. However record keeping around actions taken to resolve areas for improvement was not clear. We highlighted this to the registered manager who agreed the documentation could be improved.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were aware of the signs and symptoms people being abused may have displayed and of their responsibility for reporting any concerns promptly.

Risks to people were assessed and appropriate measures taken to either minimise or mitigate these risks whilst also taking into consideration people's choice.

Robust systems were in place to check the suitability of new staff members.

People were assisted to take their medicines safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff training in relation to the Mental Capacity Act had been identified as an area for improvement by the service but had not been delivered at the time of the inspection.

Staff received appropriate levels of training and support and were encouraged and supported to undertake additional qualifications relevant to their roles.

People were supported to maintain good health and have access to other healthcare services.

Is the service caring?

Good

The service was caring. People spoke highly of the caring nature of the staff who supported them.

People were treated as individuals and encouraged to be as independent as possible. The service had a positive risk taking policy and encouraged people using the service to make choices about their daily lives.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive. People spoke highly of the service they received and felt it was responsive to their needs.

People's needs were monitored and reviewed on an ongoing basis and where changes were required to people's package of care, these were made promptly.

Complaints about the service were investigated by a manager from another team within the council for impartiality. We found investigations were thorough and any areas for improvement were fed back to the service.

Is the service well-led?

Good

The service was well-led. The registered manager was well thought of and had a clear management structure in place allowing them to delegate duties to assist in the effective running of the service.

There was an open culture in the service that sought and acted upon the views of people, relatives and staff.

Systems were in place to monitor and develop the effectiveness of the service. However we found improvements could be made to the documentation detailing the actions taken to improve the service.

Domiciliary Care & START Service. Gateshead Council

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 2 and 7 June 2016 and was announced. The provider was given 48 hours' notice of this inspection as the service is a domiciliary care agency and we needed to make sure the provider's representative was available to assist us with this inspection. We also made telephone calls to staff, people and their relatives on 8, 9 and 10 June 2016

This inspection was undertaken by one adult social care inspector and an expert 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. Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as Healthwatch and other healthcare professionals to gain their experiences of the service. One healthcare professional informed us staff did not always consistently follow guidance. We highlighted this to the registered manager who informed us action would be taken to review these people's care plans and staff would be provided with additional training.

During the inspection we talked to 13 people who used the service by telephone and 10 relatives. We spoke with staff including the registered manager, training officer, four domiciliary care managers, two senior care

workers and three care workers. We reviewed a sample of six people's care records, four staff personnel files and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People told us they felt safe, "I definitely feel safe." This was supported by relatives, with one describing their family member as being "absolutely safe." Although some people told us they received care from a number of different care staff, the majority of people we spoke with felt they knew the staff who supported them. One relative told us; "It changes but I know everybody on the team now" and a person using the service said; "It's like having a pair of daughters." People told us their carer's were generally on time and that when they were going to be later than a few minutes they were informed of this; "They phone up if they are going to be late." Where people had any concerns about the care being provided they told us they had felt able to challenge the staff members directly and this had been resolved at the time.

The provider had a safeguarding policy and procedure in place. These documents provided details of the provider's responsibility for recognising and reporting abuse. Guidance was provided to staff on the different types of abuse and the signs and symptoms people being abused may display. Staff received safeguarding training when they first joined the service and then attended regular refresher training thereafter. Staff we spoke with showed a good awareness of what constituted abuse and of the process for reporting any concerns or suspicions of abuse. We found safeguarding was a standing agenda item in the weekly staff meetings, during which staff were encouraged to raise any concerns. We found evidence the provider had raised safeguarding alerts about other agencies also providing care to people using the service.

People using the service were provided with a 'care together' folder, which was kept in their home. This contained all the documentation relating to their care in addition to other information about the provision and management of the service. There were details within this folder of who people should contact if they felt they were being abused and of the action they could expect the provider to take. Safeguarding quality monitoring forms were also contained within this folder and these directed staff to discuss safeguarding with people using the service twice a year. In the care records we reviewed we found this form had been completed to indicate safeguarding had been discussed with these people within the last six months.

The service had a business contingency plan which covered the actions to be taken in order to continue the service in the event of an emergency. For example, we saw plans were in place to continue the service in the event of severe weather conditions; preventing staff members from being able to reach people using the service. We found the service had previously completed an exercise to test and review the effectiveness of the plan.

We reviewed the care records for six people using the service and found as part of their initial assessment potential areas of risk were identified. We found a general risk assessment was in place covering the following areas; domestic tasks, personal care, moving and handling and equipment. Where specific risks were identified in any of these areas this led to either planned reductions in risk or the creation of contingency plans to manage the risk, if this was the person's choice. For example we found one person using the service had a rug which had been identified as a trip hazard. This person's care record showed this had been discussed with the person and as they wished to keep the rug a contingency plan was put in place to manage the risk to both the person and staff. Risk assessments were reviewed on a regular basis and

where there was a change to a person's needs, their care package and any associated risk assessments were updated to reflect this.

The safety of staff was protected by the provision of health and safety training, regular reviews of people's care packages and the use of personal protective equipment such as disposable gloves. The provider had a lone working policy and procedure and a risk assessment had been completed to identify and minimise the potential risks to staff members working on their own in the community. Action had been taken by the provider to minimise or manage these risks. For example, we found staff being attacked by dogs or animals in peoples' homes had been identified as a risk. Measures put in place to minimise this risk including gathering information from people when they joined the service about any pets they had.

The service had a process for reporting on and investigating accidents and incidents to both people using the service and staff. People's care together folder's contained guidelines for staff to follow should a person suffer a fall or be found on the floor. Blank copies of the provider's injury or incident tracker record/check list were also kept in people's care together folders. This meant staff were able to quickly document injuries or incidents and monitor a person's condition following an accident or incident. We reviewed the incident report and investigation forms for two incidents involving staff members and found an investigation had taken place on both occasions and details of actions taken to prevent recurrence were clearly documented.

We spoke to the registered manager about staffing. We were advised the service had been unable to recruit due to constraints within the Council. The registered manager advised the service had coped with the demand for services during this time by offering part time staff the opportunity to work up to full time hours. The registered manager advised the service was currently understaffed and highlighted that an additional six senior carers were required. Interim measures had been put in place to manage this as the service had been unable to fill these vacancies internally. Changes had been made to the roles and responsibilities of some of the senior carers with the emphasis being on the completion of administrative duties and the provision of support and guidance to staff. From our discussions with people and staff there was no indication this staffing shortage had had a negative impact on the provision of care to people using the service. The registered manager confirmed the restrictions on recruitment were due to be lifted shortly and that any shortfalls in staff numbers would then be addressed immediately.

Staff we spoke with felt they were generally well supported, although some did tell us that it could be more difficult to get in contact with a senior member of staff on an evening. We highlighted this to the registered manager who advised staff were also able to contact 'care call' on an evening for advice and support. The registered manager also told us they were currently reviewing the rotas and that consideration would be given to the number of seniors available during the service's operating hours as part of this review.

Rotas were produced on a weekly basis and checked by senior members of staff to ensure calls had been allocated in line with people's care packages. People using the service were provided with a copy of their calls at the end of each week so that they could check them and contact the office should they require any changes to be made. In general, with the exception of 15 minute calls, staff felt they were allocated sufficient time to complete their tasks safely.

Robust systems were in place for the employment of new care workers. Potential staff members were asked to complete an application form which covered areas such as their previous experience and qualifications, a full employment history and details of two referees. Staff members were asked to account for any gaps in their employment history and appropriate checks were undertaken to establish whether staff members had a criminal record. References were sought and people's right to work in the UK was also checked. In addition to this, health checks were completed to ensure staff members were fit for work.

From the records we viewed and our discussions with people, relatives and staff we established the vast majority of people using the service did not require assistance with their finances. We were advised by the registered manager where a person did require assistance with their finances this was usually only for small items purchased on their behalf, such as groceries. The registered manager advised that staff did not have access to people's bank cards or pin numbers and support was either provided through the use of a cash card supplied by the Council or purchases were made with cash supplied by the person.

We reviewed the financial records of one person using the service. These consisted of a paper record kept in the person's care together folder. The date, amount of money provided by the person using the service and the amount of change given were recorded. All entries were signed by both the staff member and the person using the service and receipts were also retained in the person's care together folder. With the exception of one minor error which we highlighted to the registered manager we found the entries balanced. We did however highlight that receipts weren't numbered.

We looked at how medicines were managed. We viewed the provider's policy and procedure for administration and assistance with medicines. We found these provided guidance to staff on how to manage people's medicines safely in a community environment. These documents highlighted the importance of giving people using the service "as much choice and control as possible." Where the service had responsibility for medicines this was carried out by suitably trained staff who received regular refresher training.

We viewed the Medicines Administration Records (MAR) for six people using the service. We found entries were hand written but had not been checked and counter signed by another member of suitably qualified staff to confirm their accuracy. We highlighted this to the registered manager as best practice. We noted a couple of minor omissions on the MAR charts we viewed which we highlighted to the registered manager. The vast majority of these gaps were accounted for by the provider, for example as a result of cancelled calls or hospital admissions. The only other minor omission was the application of a topical medicine for one person using the service. The MAR chart stated this topical medicine should be applied twice daily however following a review of this it was confirmed the second application was only if required. We highlighted this to the domiciliary care manager responsible for this person who confirmed the MAR chart would be updated accordingly to reflect this.

We were advised by the registered manager that people's MAR charts and communication logs were returned to the office on a monthly basis and checked by senior staff members. Any discrepancies in records were investigated and where appropriate action was taken to address any performance or practice issues with staff.

Requires Improvement

Is the service effective?

Our findings

People told us they felt they received an effective service from staff who knew what they were doing. Comments included; "They are well trained they go on an awful lot of courses," "They do everything for my relative, hoists, physiotherapy" and "They make me feel relaxed, they are well trained and understand and respond to my needs, mentally as well." Relatives told us they had been involved in the planning and review of their relatives care and they felt their views and opinions were taken on board; "I am involved in care reviews and my views are listened to." We were told staff were prepared to do additional tasks for people where required; "I ask them if I want extras, they go and do it they will do anything really," and that they also helped people to remain as independent as possible; "They try to make me as independent as possible, making me feel as if I am helping myself doing little jobs." Overall people we spoke with told us the service they received was very good and they were satisfied with it.

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. We checked whether the service was working within the principles of the MCA.

The care records we viewed contained a mental capacity form, however we noted this was not always completed. We highlighted this to the registered manager who advised the service assumed people had capacity and this form was only completed when there were specific concerns about a person's capacity to make particular decisions.

In the six care records we reviewed we saw consent to care and treatment had been obtained when the person first joined the service. This had then been reviewed on a regular basis in line with reviews of the person's care plan. Staff we spoke with were aware of the need to seek people's consent prior to providing care and treatment. Staff were also aware of people's right to refuse care and treatment and said they would respect people's wishes where this was the case. People we spoke with told us staff always asked them for their permission prior to providing care and were respectful of their wishes.

We found staff training in relation to the MCA had been highlighted as an area for improvement in the monthly domiciliary care manager meeting held in May 2016. The minutes from the meeting revealed this area for improvement had been identified a number of months previously but that training had still not been delivered to staff. We discussed this with the registered manager, who advised the training team were currently working on this training. The registered manager advised senior members of staff had received training in connection with the MCA and that where staff had concerns about changes in a person's capacity they were advised to contact their manager or area supervisor for advice.

Staff we spoke with were aware of the general principles of the MCA and explained should they have concerns about a change in a person's capacity they would document this and refer it to their manager. However, one of the healthcare professionals we contacted raised concerns about staff understanding of

the MCA. We highlighted these concerns to the registered manager who took immediate action following the inspection to ensure people using the service were not at risk of harm.

We recommend that role specific training for staff in relation to the MCA and the specialist needs of people assessed as lacking capacity to make particular decisions about their care and treatment is delivered.

We spoke to the training officer about the training and support provided to staff. We were advised a training needs analysis was completed on an annual basis, during which managers were asked to provide details of staff training requirements for the forthcoming year. Training advisory groups were in operation for each service area and decided training priorities for their respective area on an annual basis, in addition to the service's mandatory training programme. The training officer advised training was designed in conjunction with other Council employees and external healthcare professionals to ensure staff were receiving up to date information from trained professionals. Staff we spoke with were complimentary about the training they received. We saw evidence a member of staff who had recently been redeployed had worked towards the Care Certificate in health and social care and other staff members told us they had been encouraged and supported to achieve various National Vocational Qualifications (now known as Diplomas)) relevant to their roles.

We viewed the provider's training matrix and found most staff were up to date for mandatory training such as safeguarding, moving and handling and health and safety. We saw evidence staff members whose training was out of date in these areas had been nominated to complete a refresher course or provided with a workbook to complete in order to refresh their knowledge.

The provider's policy for supporting staff included a commitment to providing four supervisions each year. The registered manager advised us this involved an individual supervision, a group supervision, an appraisal and development review and an unplanned observation and medication competency check, where appropriate. We viewed the provider's schedule for the provision of supervisions to staff and found not all staff had been scheduled to receive supervisions in line with the provider's policy and procedure. Staff records we reviewed contained supervision records however we found the frequency of these did not always comply with the provider's policy and procedure. We highlighted this to the registered manager. Following the inspection the registered manager sent us a revised copy of the supervision schedule which showed all staff had now been scheduled to receive four supervisions.

Staff we spoke with told us they received regular supervision sessions and generally felt supported by the provider. Staff advised weekly team meetings took place during which they had the opportunity to raise any concerns, either during the meeting or on a one to one basis afterwards. Where concerns were raised, staff felt these were dealt with promptly and feedback was provided to them. Where performance issues were identified we saw evidence staff were provided with additional supervision sessions to address areas for concern and emphasise expected standards of practice.

The provider had a procedure for meeting people's nutritional needs. This provided information to staff on the limitations of meeting people's nutritional needs in a community based service. Guidance was provided about how this could be mitigated through the maintenance of clear records detailing people's food and fluid intake and vigilance around changes to people's condition. The procedure also detailed the process for completing a nutritional risk tool of people using the service. And where this indicated a referral to the dietetic service was required, staff were reminded of the importance of informing the person and seeking their consent before this referral was made.

From the records we viewed and our discussion with people, relatives and staff we established the vast

majority of people using the service only required minimal assistance with their food and fluid intake. Records showed staff generally prepared meals for people and training records showed staff had received appropriate food hygiene training.

Care records included details of people's likes and dislikes where appropriate and provided guidance to staff on the level of assistance people required in relation to their food or fluid intake. Where people had a specific requirement in this area, sheets were available to monitor a person's intake.

People's health needs were assessed when they first joined the service and then on a regular basis thereafter. Contact details for relevant healthcare professionals were documented in people's 'care together' folders and staff we spoke with knew where to find these details. We found the provider worked in conjunction with other agencies in the provision of care to some people using the service and this was managed efficiently. We also saw evidence that where required staff would assist people to attend appointments. One comment we saw was, "thank the staff for accompanying [name] to their hospital appointment."

Good

Is the service caring?

Our findings

People we spoke with were positive about the caring nature of the service they received. Comments included; "Genuinely caring and very friendly," "It's the right name for them, carers that's what they are," "Very caring, they seem genuinely attached to [relative]" and "[relative] classes them as friends." One relative we spoke to told us one of the carers had spoken about their family member in the third person, however they told us they had challenged the carer about this and that this had been resolved straight away. People told us their carers treated them respectfully; "They are always respectful and involve me in their conversations" and another told us the carers "Always ask for consent, always very respectful." People also felt that their carers maintained their privacy and dignity, "They respect my dignity; they always close the bathroom door," and other people told us how they had been actively involved in their care, "I have conversations about how my relative is cared for all the time" and "They let me do as much as I want."

'Care together' records we reviewed contained details of people's life histories including their likes and dislikes, places of importance and details of their immediate support network as well as any relevant healthcare professionals. Staff we spoke with told us a copy of people's 'care together' folder was contained in their home and they could use the information recorded to provide care to people in line with their individual needs. People we spoke with felt staff knew them well; "They are brilliant and know my likes and dislikes."

The majority of the people we spoke with did not feel rushed by staff during calls and told us staff would complete any additional tasks they asked them to. Staff we spoke with felt that with the exception of 15 minute calls, they were generally allocated sufficient time to provide people with the support they required. One person told us "They chat and offer to do things for me" and a relative told us and "One girl likes to hear about the early days which keeps [relative] chatting away." One staff member we spoke with told us when they had time available in their rota they would visit people using the service to spend some quality time with them. The staff member said they would always check this was okay with the office first and stated that as people using the service sometimes did not see anyone else all day when they had the time in their rota they liked to make additional calls to these people.

The service was aware of the need to respect people's preferences. People's 'care together' folders contained an "All about me" document which captured details of a person's preferences in specific areas such as communication method or personal care. People we spoke with felt if they had any specific preferences these would be respected. The domiciliary care managers we spoke with provided examples of occasions when care packages had been changed in response to feedback from people using the service or their relatives. This was supported by comments we received from one relative who stated: "I would tell them if I had any problems and they would put it right." Records from carer consultations also provided evidence that people's care packages had been changed in line with people's preferences: "Carers on evening were changed as [name] was uncomfortable with a male carer providing personal care."

We found the care records we viewed were written in a respectful manner with people being referred to in the first person and clear evidence of their involvement in their care planning. We saw evidence that daily

communication logs were returned to the office on a monthly basis. The registered manager informed us these records were checked by a senior member of staff for accuracy but also to ensure the content was appropriate. We were shown records of the action taken against one staff member who was found to be recording inappropriate comments in a person's daily communication records.

Care records we reviewed had been signed by the person using the service and there was evidence these were reviewed on a regular basis. We found people using the service had been asked to identify goals for the provision of their care and these were clearly documented in their records. For example in one of the care records we viewed the person's goal was "to be able to take medication consistently." We saw where there was a change to a person's circumstances care plans were reviewed and amended in consultation with the person or their representative where appropriate. The provider had a record of any people using the service who had an advocate and we saw leaflets in people's care together folders provided information to people about advocacy services.

The service had a positive risk taking policy. The aim of this policy was to support people using the service to make their own informed choices. Staff we spoke to were aware of the importance of involving people in their care and treatment. One staff member told us about the importance of getting people's views and opinions on their care and treatment and explained how they would offer people choice on a daily basis. People's care records also noted the importance of asking people and providing them with choice. For example; "[name] may want a shave, please always ask."

Staff we spoke with were aware of the need to respect people's privacy and dignity and gave examples of how they would do this. For example one staff member told us they would wait outside the room while a person went to the toilet. Another staff member explained how they would cover people with towels whilst providing personal care. People and relatives we spoke with confirmed staff were respectful, they always asked for consent and they maintained people's privacy and dignity whilst providing care to them.

We asked the registered manager about the provision of end of life care. We were advised, where a person was receiving end of life care from the service, details of their wishes were captured in the "all about me" document contained within their care together folder. This contained details of any advanced decisions including do not attempt cardio pulmonary resuscitation (DNACPR) agreements as well as a record of the person's wishes for things such as their funeral and who they wanted the service to contact.

We viewed the records for one person receiving end of life care and found the "all about me" document had been completed and provided specific details of the person's wishes around their end of life care. We found the person had a DNACPR in place which was in date and had been completed appropriately.

We asked the registered manager about the support provided to staff involved in the provision of end of life care. The registered manager told us staff members who provided end of life care had expressed an interest in this and had been provided with additional training in this area. For example, we were advised these staff members had received additional communication training to assist them in speaking to people about their wishes around their end of like care.

The registered manager showed us a thank you card the service had recently received from a relative which commented on the excellent care provided to their relative at the end of their life. It stated the "reliability of the team in their attendance, quality of care and their conscientious attention to record keeping was exceptional" and one of the relatives we spoke with told us "A carer stayed with me when my [relative] died, they took over and sorted things out, like the police, and stayed over until I had calmed down, very kind."

As part of an assessment of people's needs, factors such as their age, disability, gender and religion were taken into consideration. Where people were identified as having a particular need in any of these areas, there was the capacity to incorporate this into their care plan. The registered manager showed us a copy of the equality and diversity folder which had recently been created. This contained information about adaptations that may be required to the care provided to people as a result of things such as their religion or beliefs. For example specific guidance was provided to staff about adaptations that may be required to a Jewish person's care. The registered manager informed us each of the domiciliary care managers had a copy of this folder which was made available to staff.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs and that where changes were required to their package of care these were made promptly. One person told us "They changed my care to suit my needs, they were there to reassure me" and another said "They changed the whole thing when I broke my arm and couldn't do things, really accommodating." Carers were described as being effective in responding to emergencies; "They deal with emergencies brilliantly." Relatives also told us they felt carers were receptive to any changes in people's condition and took action to ensure people received appropriate treatment. For example one relative told us "When a carer was concerned about [relative's] health they phoned up the paramedics and stayed until they arrived and made sure they took [relative's] medicines to Hospital." The majority of the people we spoke with told us they had not needed to make a complaint; "I cannot find any grounds for a complaint" and "I have never wanted to make a complaint". However, where people had complained, they felt this had been dealt with appropriately and they had received a positive outcome.

An assessment of a person's needs was completed when they were first referred to the service. These assessments covered areas such as health, mobility, communication preferences, areas where support was required and details of the person's goals. There was evidence people, or their representatives were involved in this process. Consideration was also given to the most appropriate service for the person's needs, such as reablement or long term support and where necessary, we saw evidence people had been referred internally to other services. For example one person who had been receiving short term reablement services was assessed as requiring long-term support. The person was informed of this and asked for their consent to be referred to this service for further assistance.

Information obtained from people's initial assessment was used to produce individual care plans. These provided specific instructions about the care people required at each visit and provided guidance to staff on how to support people in the way they preferred. Care plans provided guidance to staff on the level of assistance people required in specific areas such as mobility and communication. Staff we spoke with told us care plans were always detailed enough that they knew how to meet people's needs. They also informed us that prior to providing care to people they would always review their care plan and communication records to see whether there had been any changes to the person's needs or preferences.

Staff told us the weekly team meetings provided them with an opportunity to discuss the requirements of people using the service. This included any people who were new to the service as well as any changes to existing people's care packages. Staff we spoke with felt they well informed about the care people using the service required and were able to raise any concerns they had.

In the care records we viewed we saw evidence regular reviews were completed of people's care plans to ensure they were accurate. We saw evidence people were involved in these reviews, or where appropriate their interests were put forward by a relevant representative. One of the domiciliary care managers told us there had been a change in the needs of one of the people they supported and that as this person received care from a number of different agencies a joint meeting had been called to conduct this review. The domiciliary care manager advised this was to ensure all those involved in the person's care were able to

have input into this decision and agree any changes to the person's care package jointly.

We reviewed the complaints log and found 11 complaints had been made in the previous 12 months. Of these complaints, three were formal and the remaining eight were informal. We viewed the records held by the provider in connection with one of the formal complaints and found details were held of the nature of the complaint, any investigation undertaken and the outcome. We found an outcome letter had been sent to the complainant and action had been taken to address the issues identified with those staff members involved directly. In addition to this, we saw evidence the issue had been discussed generally with all staff at one of the weekly staff meetings to impart learning and reduce the likelihood of a repeat incident.

The registered manager advised us that for the purposes of impartiality any complaints about the service were assigned to a manager from another team within the Local Authority. Once the investigation was complete, the investigating manager would then meet with the registered manager and the relevant domiciliary care manager responsible for the person using the service, to whom the complaint related. This meeting was to discuss their findings and to feedback any areas for improvement.

We also reviewed the provider's compliments file and found 319 compliments had been received in the previous 12 months. One compliment from December 2015 stated: "Although I do not have regular care, I cannot thank them enough as when I have needed overnight, they have been very good." Another compliment from October 2015 stated: "Told the carer that they are a very capable carer and that all the carers are lovely." One from March 2016 stated; "Absolutely essential service. Markedly reduced [relative's] hospital admissions with excellent quality of care and attention to vital detail in personal welfare." Comments in the compliments file supported what people we had spoken with had told us about the service and the staff.

We reviewed the results from a service user feedback questionnaire issued in August 2015. We found 311 responses had been received and the service had received largely positive responses throughout. 88% of people who responded rated the service as good or excellent overall, 80% rated the quality of the information and advice they received and the ease of access as good or excellent. 86% of people rated the service as good or excellent in terms of being treated with dignity and respect and being able to share their views and opinions and 85% of people rated communication as good or excellent.

The registered manager told us feedback was requested from family members of people using the service within 72 hours of them commencing their care package. We viewed a selection of these records and found relatives were asked whether the service was meeting their expectations, the benefits of the service for them as a carer, whether they had any concerns and any suggestions for improvement. We found the majority of responses were positive and that where people had any areas for improvement these had been addressed and responded to promptly.

'Care together' folders we reviewed provided people using the service and their relatives with names and contact numbers for people involved in their care. All of the folders we viewed contained a feedback card for people to complete if they had any comments about the service. The majority of people and relatives we spoke with told us they had been asked for their views and opinions on the service and that they knew who to contact should they need to.

Good

Is the service well-led?

Our findings

People told us they felt the service was managed well. Relatives and people we spoke with knew who the registered manager was and knew who to contact should they have any concerns. People told us they were happy with the standard of care provided, comments included; "Excellent service, excellent care," "They know exactly what to do, well managed" and "Management team and everyone from top to bottom absolutely brilliant." One person said; "Management very approachable, site manager very friendly" and another said "Paperwork really clear, you have a meeting then it goes in your book." Overall people we spoke with were happy with the management of the service and the level of care provided by all staff members.

The service had a person-centred, open, inclusive, empowering culture. The registered manager was open and honest with us about the recent review that had been conducted of the service. They advised us consultations had been held with all staff members and people using the service had also been kept informed throughout this process. Where people using the service did not have family or friends who were involved in their care, the registered manager advised they had been offered the opportunity to access advocacy services. People we spoke with confirmed they had been made aware of the current review of the service and expressed their desire to continue with the service. Staff members also felt they had been kept well informed of the review of the service and the potential implications this could have for them.

We saw records from the weekly staff meetings that were held. During these meetings, staff members were encouraged to raise any concerns or issues. The domiciliary care managers told us where staff did not feel comfortable raising concerns in a group environment they had the opportunity to speak to a senior member of staff on an individual basis following the meeting. Staff members we spoke with were aware of this and told us they felt supported by the management of the service. We were told concerns were taken seriously and responded to appropriately.

The service had a registered manager in post who was aware of their responsibilities. We were advised the average length of time staff had worked for the service was 16 years and that the majority of staff in senior roles had worked their way up through the service over a number of years. Staff we spoke with felt proud to work for the service and told us how much they enjoyed their jobs.

The registered manager explained how the service was organised into a number of smaller teams which were each headed by a domiciliary care manager. The registered manager delegated a number of roles and responsibilities to these domiciliary care managers to assist her in the effective running of the service. We found senior staff members had responsibility for conducting observations and supervisions with more junior members of staff. All of the staff members we spoke with were aware of who to contact should they require assistance and told us that if their immediate manager or area supervisor was not available they knew how to get in contact with one from a different team or with their domiciliary care manager.

The provider had a range of systems in place for checking the quality of the service. These included the completion of quarterly peer inspections, unplanned observations and monthly quality monitoring checks

on people's medication records and communication logs. In addition to this, feedback was requested from people and their relatives through a variety of different methods including telephone calls, surveys and reviews.

We saw evidence that issues or areas for improvement identified were carried forward and action was taken to resolve these. However we found records documenting this were not always easy to follow. We highlighted this to the registered manager, who agreed the documentation could be improved.

The registered manager told us the quality assurance manual was being revised and as part of this process a number of policies and procedures were under review. We were informed changes were being made to these policies and procedures to make them more applicable to community based services. Senior staff members within the service had been given the opportunity to be involved in this review and the registered manager confirmed in the intervening period staff were continuing to work in line with the existing policies and procedures.