London Care Limited

Comfort Call (Newark)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

This announced inspection took place on 19 June 2018. This service is a domiciliary care agency and provides care and support to adults living in their own houses and flats. During our inspection 181 people were using the service.

The service did not have a registered manager at the time of our inspection. There had not been a registered manager in post for a period of eight months. 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. The present service manager told us they were going to apply for registration with us. We will monitor the progress of their application when it is received.

When we last visited the service, the provider was in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people did not have a suitable plan in place to guide staff in how to meet their needs.

During this visit, we saw improvements had been made at the service and people who were receiving care did have a care plan in place. However, there were further improvements needed to fully document people's preferences in relation to their care.

People felt safe and were supported by staff who knew what action they should take if they suspected abuse. Risks to people's health and safety were assessed and measures were in place to reduce the risk of harm to people. People's needs were met by a regular group of staff who arrived on time and gave people the support they needed. When needed people were provided with medicines by staff who received the required training. People were protected by the prevention and control of the spread of infection and action was taken in response to any accidents or incidents which occurred when the service was being delivered.

The majority of people's needs were assessed using nationally recognised assessment tools, however one assessment tool used had been modified for use by the provider but had not been validated and tested for reliability.

People were supported by staff who had received an induction when they commenced working at the service and training relevant to their role. When required, people were supported to eat and drink enough and were supported with their health care needs. Staff were provided with information about people's health conditions and supported people should they need to access health professionals.

The service was not working within the principles of the MCA. People were not always supported to have maximum choice and control of their lives to ensure staff supported them in the least restrictive way

possible. There was no evidence of capacity assessments or best interest meetings, for people who may lack the capacity, to make their own decisions to ensure any decisions made for people were the least restrictive and in their best interests.

People were supported by staff who were respectful, kind and caring towards them. People's views on their care were considered and staff worked to maintain people's privacy and dignity when providing care.

The majority of complaints and concerns raised by people to the service were dealt with appropriately. However, one person told us their complaint had not been resolved to their satisfaction. Following the inspection the service manager sent us information to show they had addressed this issue.

There was a lack of evidence in care plans of people's end of life care or advance care decisions to show what their preferences may be.

The service manager and their management team were open and honest. They were supportive towards people, their relatives and the staff who worked at the service. The quality assurance systems in place were used effectively to monitor performance and quality of care. The registered manager responded positively to changes and used information to improve the service and care people received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People felt safe and were supported by staff who knew what action they should take if they suspected abuse.

Risks to people's health and safety were assessed and measures were in place to reduce the risk of harm to people.

People were supported by a regular group of staff who arrived on time and gave them the support they needed.

When required, people were supported with their medicines by staff who received the required training.

People were protected by the prevention and control of the spread of infection.

The service had processes in place to help them learn from adverse incidents.

Is the service effective?

Requires Improvement

The service was not always effective.

The majority of assessment tools used to assess the needs of people were nationally recognised tools. However, one tool used had been modified and had not been validated and tested for reliability.

The service was not working within the principles of the MCA. There was no evidence of capacity assessments or best interest meetings that would ensure any decisions made for people were the least restrictive and in their best interests.

Staff received appropriate training for their role.

When required people received the help they required to support their nutritional needs.

People's health needs were met and staff supported people to access health professionals when required.

Is the service caring?

Good

The service was caring.

People were supported by staff who were kind and caring.

Staff respected people's preferences and wishes about how their support was delivered and considered their views when developing their plans and care.

People were supported to maintain their privacy and dignity.

People were supported to maintain their independence as much as possible.

Is the service responsive?

Requires Improvement

The Service was not always responsive.

People's care plans lacked some detail in places and did not always fully document the person's preferences in relation to their care.

There was a lack of evidence in care plans of people's end of life care or advance care decisions to show what their preferences may be.

The majority of complaints and concerns made to the service were managed and resolved to the satisfaction of people who used the service.

Is the service well-led?

Requires Improvement

The service was not always well led.

At the time of our inspection the service had been without a registered manager for over eight month. A new service manager was planning to apply to become the registered manager but at the time of the inspection had not made the application.

There was an open and transparent culture in the service where people were listened to and staff were valued. The provider sought and acted upon people's feedback in relation to the service they received.

There was a robust governance system in place to monitor the

quality of the service.

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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.

We inspected the service on 19 June 2018 and the inspection was unannounced. The inspection team consisted of two inspectors and an assistant inspector. An Expert by Experience undertook phone calls with people who used the service, or their relatives, to gain their views of the service. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to our inspection we reviewed information we held about the service. This included information received and statutory notifications. A notification is information about important events which the provider is required to send us by law. We sought feedback from health and social care professionals who have been involved with the service, and commissioners who fund the care for some people who use the service.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

Prior to, during and following the inspection we spoke with 19 people who used the service and five relatives. We also spoke with five care workers, one team leader, one care coordinators, the trainer, the quality assurance manager, the regional manager and the service manager. We looked at all or parts of the care records of 10 people who used the service, medicines records, staff recruitment and training records, as well as a range of records relating to the running of the service including maintenance records and quality audits carried out by staff at the service.

Good

Is the service safe?

Our findings

People we spoke with had confidence in the staff who cared for them. One person said, "I feel very safe with them all, they know how to look after me very well." Another person said, "I have every confidence in them, so I do feel very safe, yes." A further person told us of a safeguarding incident they had been involved with. They told us the service manager had responded quickly and had dealt with the issue appropriately. During our inspection we saw evidence to show the issue had been addressed quickly by the service manager. They had made the local safeguarding team and ourselves aware of the issue and followed guidance from the safeguarding team.

Staff we spoke with told us they underwent face to face safeguarding training when they were first employed and had received regular refresher training. One new member of staff told us they had found this very useful and said it was "in-depth." We spoke with staff about the types of abuse people who were receiving care in their own homes could be exposed to. The staff we spoke with were able to identify the different types of abuse and how they would recognise if someone were being abused. One member of staff said, "I go to the same people all the time, I would pick up on their moods and know if something was wrong." Another member of staff went on to say they knew who to report any safeguarding concerns to. They told us they always had contact numbers for the management team in the office and could talk to their care coordinator or the service manager. Staff told us they felt confident that issues they raised would be dealt with appropriately and they were aware of the contact details of the local safeguarding team should they need them. The comments and evidence we saw showed the provider worked to safeguard people in their care.

The risks to people's safety were assessed when they first started using the service and updated when any changes to the person's needs arose. The risk assessments we saw showed the level of risk to the person and the measures in place to reduce the risks. Where people required support to mobilise or move from one place to another, the equipment used was identified and the number of staff required to support this. Staff we spoke with told us they had received practical training in the use of the equipment they were required to use when supporting people. They told us they would always check the equipment before using it to ensure it was fit for purpose.

We saw there was risk assessments in place to support positive risk taking for individuals, for example one person who had been identified as a choke risk still wished to eat and drink particular things that may present a choke risk to them. We saw the service had obtained guidance from health professionals who assessed the person and had outlined the risks to them. Together the health professionals and the person had agreed a suitable diet that took into account the person's preferences. As the person's needs changed we saw further assessments and changes had been recorded to give clear guidance for staff to help them support the person in the way they wanted to be supported.

The service also undertook an environmental risk assessment for each person who was receiving care. For some people this had also resulted in the service liaising with the local fire service to enter individuals on the vulnerable adult register at the fire service. This meant should there be a fire at the person's home the fire service would have information on the support people needed prior to attending the fire. All the issues

above show the provider worked to ensure people were protected from avoidable harm.

People told us that usually staff arrived on time. One person said, "Yes they are usually on time, I don't have any problem." Another person said, "Yes the carers are very good with their time keeping." People accepted that there were times staff were late as they could be held up with another client. One person said, "(Staff are) not always on time but they do contact me to let me know." A relative said. "They (staff) are generally on time, occasionally someone will ring to say why they are running late."

People we spoke with, also confirmed that staff stayed for the correct length of time and their care did not feel rushed. One person said, "Yes they always stay and do everything I need doing." A relative we spoke with said, "They (staff) do stay for the right time and do everything [family member] needs, no problem." Another relative said, "Yes they (staff) always stay and never rush around. They do everything we need doing."

Staff said they normally had sufficient time for each visit and if they needed to stay longer the service paid for their time. They said if the person regularly needed additional time they informed the care coordinators. Most staff said they undertook visits to the same group of people and this provided continuity for people using the service and enabled them to build relationships with people. One staff member told us they were normally able to pick up additional shifts if they requested them. The provider return form (PIR) noted that the service worked to employ staff from the area where the care calls were required and staff us spoke with told us their calls were local to where they lived. The service manager told us they were constantly working on recruiting staff and had undertaken a leaflet drop in one of the areas where they wanted to recruit staff. This showed the service worked to provide consistent care to meet the needs of people at the service.

The service had safe recruitment procedures and policies in place. Appropriate procedures had been followed before staff were employed. All necessary checks had been undertaken before an individual had started work, such as references from their previous employers, and any gaps in employment had been explained. The provider requested criminal records checks through the Disclosure and Barring Service (DBS) as part of the recruitment process. The DBS helps employers ensure that people they recruit are suitable to work with people who use care and support services.

People who needed support with their medicines told us they received the level of support they required. One person said, "Yes they give me my tablets, there has never been a problem with it." Another person said, "They just prompt me to take them myself." The majority of care plans we viewed clearly showed staff the different levels of support people needed and staff we spoke with discussed the different support people needed. However, one person's record had some conflicting information as to whether they were able to manage their medicines themselves or whether they required assistance to access their medicines and prompting. We spoke with the care coordinators who told us the person liked to retain control of their own medicines as much as possible, and staff input varied.

The care co-ordinator agreed that as staff had some responsibility for prompting the person, staff should complete the MAR indicating whether they had verified the person had taken their medicines or had made the medicines available for the person. A care coordinator immediately informed the staff who supported the person of the requirements and clarified the information in the person's care plan.

One member of staff told us none of the people they supported required any assistance with their medicines. Either the person managed them themselves or their relatives supported them. The staff member told us they had received safe handling of medicines training, but they told us they would ask for update training if the situation changed for the people they supported. Other staff told us as well as their training their care coordinators did undertake spot checks to ensure they managed peoples medicines

safely and in line with their care plan.

People we spoke with did not raise any concerns about staff practice in relation to reducing the risk of infections. Staff were provided with appropriate personal protective equipment (PPE) and they received infection prevention and control (IPC) training, and safe handling of food training to support them in their role. Staff were aware of the importance of hand washing, when they should wear, and how to dispose of PPE when supporting people. This demonstrated the provider had taken steps to ensure people were protected through the effective prevention and control of infection.

The service manager told us they had a number of ways of ensuring learning took place in relation to incidents, errors or accidents at the service. They held staff meetings to discuss issues and had themed staff supervisions. One member of staff told us they also received group text messages if there were concerns the service manager wanted all staff to be aware of. The service also used their own internal reporting system to look at trends and identify learning from adverse incidents.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act (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.

We found the provider was not always working within the principles of the MCA. Staff we spoke with did have some limited knowledge of the MCA and showed knowledge of how to support people who may struggle with making their own decisions. However, staff had not undertaken any capacity assessments of people who needed support to make particular decisions. There was no evidence of capacity assessments or best interest meetings that would ensure any decisions made for people were the least restrictive and in their best interests.

Some people's care records stated that relatives had lasting power of attorney (LPOA) in areas of health and welfare or finances, however there was no evidence to support the statements. We discussed these issues with the service manager and found there was some confusion as to whose responsibility it was to undertake mental capacity assessments. They felt there was a need for further training in this area for themselves and the care coordinators who may undertake this role in the future. They told us there was already further training arranged to support them manage this aspect of people's care. They told us they would address the concern to ensure people were supported appropriately when they lacked the capacity to make their own decisions. The service manager also told us they would update their records to ensure where required they had copies of the documentation relating to LPOA.

People told us their needs were assessed when they first started to use the service. The majority of the assessments tools used to assess the needs of people at the service were nationally recognised validated tools. Using nationally validated tools ensures that the care needs of people were managed in line with nationally recognised guidance. However, one tool the service used had been adapted from a nationally recognised toolwhich meant it had not been validated and tested for reliability. We raised this with the service manager who told us they would address this issue.

People we spoke with gave positive feedback about the competence of staff supporting them. One person said, "Yes I think they are very well trained, they know exactly what to do and how to do it." Another person said, "I feel they are well trained, they have all the skills needed to make excellent carers." Relatives we spoke with supported these comments and one relative said, "I think they are well trained and very professional carers." A second relative said, "We think they are very well trained and know exactly what my (Family Member) needs to make sure she is well looked after."

Staff we spoke with felt they received appropriate training for their roles and we saw the service provided training using a variety of trainers. A member of staff who had started at the service within the last six months told us they undertook their induction training with a group of new staff and had enjoyed this as

they forged some relationships with other care staff. They also shadowed an experienced member of staff for two days and then provided care for a person who required two carers to support them so they were teamed with an experienced member of staff. The company's induction training was delivered over five days and was provided in the classroom with questionnaires for staff to complete, to test their understanding at the end of each topic. Staff were not allowed to work until they had undertaken their induction training. This consisted of health and safety, safeguarding, risk assessment, fire safety, moving and handling, first aid, infection control, food hygiene, nutrition and hydration, mental capacity, record keeping and medicines management.

Refresher training for staff had been provided in the same way, but the provider was in the process of rolling out a "fitness to practice passport" which consisted of distance learning modules and a test of knowledge at the end. There was a training plan for the year and 82% of staff were up to date with their training, with plans in place to support the remaining 18% of staff to become up to date with their mandatory training. This showed the provider worked to provide a competent group of staff to support people with their needs.

People who staff supported with their meals told us they were happy with the level of help they received. One person said, "Yes they make my breakfast and heat a meal up, usually at lunch time. I choose what I fancy." Another person said, "Yes they cook my lunch for me and are very good. It is always a lovely meal."

Staff we spoke with were clear about the different levels of support people required in relation to their nutritional needs and their responsibilities in ensuring they checked food was in date and appropriately covered and labelled when opening. Where people had required the input of health professionals in relation to their diet we saw the relevant referrals had been made and the guidance given had been documented and followed by staff. This showed where the service was responsible for managing peoples nutritional needs they did so in a safe way.

People told us if they had been unwell, staff had supported them to get the help they needed. One person said, "Yes they have called the doctors for me in the past, when I have not been well." Relatives told us the care staff knew their loved ones well and if there were any health concerns, they would ring them or let the person's GP know. The service manager told us some people were under the care of the district nurses and the care staff worked with the district nurses, following their guidance for particular aspects of people's care.

Staff we spoke with told us they felt confident to highlight any health concerns they had about the people they supported. One member of staff told us one person they supported who had an underlying chronic health condition had looked unwell during their morning visit. They had called the GP, as they were aware that if they had not ,the person's condition would deteriorate and this could result in the person being unwell. This demonstrated staff had the knowledge of the health needs of the people they supported and understood their responsibilities in relation to managing those needs.

Good

Is the service caring?

Our findings

People we spoke with told us they found the care staff who supported them treated them with respect and were kind and caring. One person said, "Very much so. They are all lovely people." Another person said, "They (staff) are very kind, and so helpful nothing is too much trouble for them, they never moan about anything." A relative we spoke with said, "I can't fault them (staff), they are so kind and considerate." They went on to say that their relative had a problem with a company that kept ringing them. The care staff alerted the relative and got the phone number so the relative could deal with the issue. Another relative said, "There are no problems with them (staff) they are lovely."

Staff we spoke with told us they enjoyed their job as they got to know the people they supported. They told us they went to see the same people regularly and built relationships with them. One member of staff told us they had supported some of the people they cared for over a number of years and they had become their friends.

The majority of people told us they were cared for by a consistent group of staff and were introduced to new staff before they provided care for them. One person said, "They (new staff) usually come with a usual one first." Another person said, "Yes (introduced to new staff before providing care) but it does not happen often." One person did tell us they had in the past had members of staff they had not been introduced to undertake their calls.

The service manager told us the care staff worked in teams, so if one staff member was on a day off another member of staff who was known to people provided care. They told us they might need to send a member of staff not known to the person if there had been short notice sickness but they worked to keep this to a minimum. We also saw that care coordinators and the service manager covered calls if there was short notice sickness. The staff we spoke with told us there was a caring attitude among staff as people told them they were happy with the different members of staff who supported them. One member of staff said, "The feedback I get from people I support is that other carers are kind and they feel comfortable with them." This showed the service worked to provide people with care staff who were known to people as much as they possibly could.

People's views on their care were incorporated into their care plan. One person we spoke with told us the care coordinator had sat with them and undertaken an assessment they felt their views were listened to.

We saw evidence of peoples input in the plans we viewed. People had provided information about the care they required when they first began using the service. Staff we spoke with were able to discuss people's preferences. One staff member told us they got to know people how wanted their care provided. One person was supported when their relative went out, and the timing of this support varied dependant on what the relative needed to do. Staff worked with the person and their relative to meet their preferences. We saw evidence in the daily logs we viewed of how staff had ensured people's preferences were accommodated in relation to their choice of meals, or how they received personal care. This showed staff worked to provide the care people required in the way they wanted it.

People told us they were able to choose the times they wanted their care provided. One person said, "Yes the times are fine with me and I talk to the carers about what I need doing." Relatives we spoke with echoed these views. One relative said, "Yes we chose the times and they are fine, the carers do whatever is needed."

No one using the service was using the service of an Advocate, however the service did have information available for people should they require this service. The registered manager told us if they were alerted that a person may require an advocate they had a referral form they would support the person to complete to ensure they received any support they needed.

People told us staff considered their privacy and dignity when providing care and treated them and their homes with respect. One person said, "They are all very respectful towards me and treat my home like their own. They are very clean and tidy up after themselves." Another person said, "They are very respectful, especially when they are helping me shower." A relative we spoke with told us, "They treat (Family member) as if she were their mother and look after the house the same."

Staff we spoke with showed a good understanding of their role in ensuring people felt comfortable with them when they provided care. One staff member told us they understood how difficult it was for people when receiving personal care. They said they treated people in the way they would want to be treated and was careful to maintain people's privacy. The service manager told us they were in the process of introducing dignity champions and planned to raise awareness of the different aspects of maintaining people's dignity at team meetings and staff supervision's. They told us this was an aspect of care that was monitored through the spot checks they were undertaking on staff practice. This showed the service considered people's right to be treated with respect and dignity when providing care, and worked to maintain the standards of care.

Requires Improvement

Is the service responsive?

Our findings

When we last visited the service, we found they were in breach of regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Some people did not have a suitable plan in place to guide staff in how to meet their needs. Staff had begun providing care and support to these people without an accurate care plan being in place. Other people had care plans that were not always sufficiently detailed to describe what people's needs were and how these should be met. They also lacked the details that would make them individualised and personal plans for the person concerned.

The care plans we viewed at this visit showed some improvements and the provider was no longer in breach of this regulation. We viewed care records for people who had very recently begun to use the service and found there had been a care plan developed with the person to support staff with providing care. Care records contained a comprehensive assessment of each person's care needs, previous medical history and care plans to meet the identified needs. They also contained some information on the person's life history. However, they lacked detail in places and did not always fully document the person's preferences in relation to their care. This meant the different staff supporting the person may not provide care in the way the person wished

The care plans did not always provide information for staff on the person's long term medical conditions. For example, some people had diabetes, their care plans did not identify signs of low and high blood sugar levels, and the action staff should take if the person was unwell. However, the information needed to provide care for the person was recorded in their plans which included a routine for each visit and the tasks the carers were responsible for. Staff also provided a good level of detail in the daily logs of care.

We spoke with the service manager about the care plans and they told us they were aware that further improvements to people's care plan could be made. They told us they had already begun to address this. They had been working with the care coordinators, and new team leaders who supported care staff working in people's homes. Their role was to ensure people's care plans were reviewed regularly and they used information from people, relatives and care workers to ensure accurate and personalised guidance was recorded in people's care plans.

However, some care plans we viewed had clear, detailed information on particular aspects of care people needed. For example, the care plan for one person who had difficulties in swallowing gave staff guidance on how to prepare the different aspects of the person's diet safely. With the information provided from health professionals on this aspect of people's care.

People's ability to access the information provided by the service on their care was assessed when they first started to use the service. One of the care coordinators told us any issues highlighted in relation to people's communication needs would be lead to the person being provided with the information in a format they could understand.

We viewed the service user guide that was provided to every service user. The document contained a great

deal of information and was designed to be used by people and their relatives. It stated that people would be given information in a way they would understand. However this information was on page 11 of the document. There was also some brief information on how the service could support people to access advocacy services, but the information was on page 25 of the document. This meant the information that would support people with communication issues was not prominently displayed in the document. We discussed this with the care manager who told us they would address the issues with the management team who produced the document for the company. The service manager also told us information in the service user guide could be provided for people in braile, easy read or larger font.

The service user guide provided details of how people could complain should they have any concerns about their care and most people we spoke with told us they could speak with the care staff or call the office. However, one relative we spoke with told us they had complained about an issue relating to their relation's care, but had not had a resolution to the complaint. We spoke with the service manager about this, they told us the member of staff who had been dealing with the issue had been off sick. They assured us they would deal with the issue as a matter of urgency and they sent us information to show how they had resolved the issue following our inspection.

We did receive information from other people and their relatives to show that when they had raised concerns or complaints the issues had been dealt with to their satisfaction. People told us they felt comfortable about raising concerns if they had any. One person said, "I would have no qualms complaining but have never needed to." Another person said, "Yes I can speak up for myself, and do if need be. I have no complaints though." This showed the present management team were responsive to complaints made to the service.

During our inspection we could find no evidence in the care plans of people's end of life care or advance care decisions to show what their preferences may be. The assessment tool used to assess people's needs had a question about this aspect of care but none of the care plans we viewed had the information completed. This meant staff would not have the necessary information to help them support people with their choices at this point in their lives.

No one using the service was receiving end of life care and prior to our inspection the service had not been contracted by the local authority to provide this aspect of care. However the Quality assurance manager told us this was an aspect of care that was being explored with the local authority teams so the service would be able to support people at this period in their life. The Service manager also told us the service did provide end of life care training for staff. However, in view of the possible increase in clients who may require this care they were re-looking at the training to ensure it met the needs of the staff providing this care.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was not a registered manager in place at the service. The last registered manager had de-registered in October 2017. The present service manager had been in post for nine weeks and told us they were intending to apply to become the registered manager for the service. We will monitor the progress of their application. The provider was aware of their responsibilities as part of their registration with the CQC to ensure we were informed of any reportable incidents. These include reporting serious injuries, allegations of abuse and events that could stop the service running appropriately. The ratings for the last inspection were displayed on the provider's website and at the service.

People we spoke with told us they were able to speak to managers at the service should they need to. A number of people told us they had no problems getting through to the office when they needed to. One person said, "Yes people in the office are always prompt and helpful." During our visit to the office, the atmosphere was calm and relaxed and it was apparent that any visiting care staff felt comfortable speaking with the service manager and their team.

People we spoke with felt the service was well managed as the care coordinators sorted out any issues they had with areas such as call times. People told us they had visits from the care coordinators or team leaders who undertook quality checks on their care. One person said, "They do drop in and sometimes step in if they are short staffed, so I see them then."

However, records we viewed showed that only 66% of staff had spot checks in the provider's designated time frame. A recently appointed care coordinator told us they were behind with spot checks as their team had had a team leader who had been on sick leave. They told us the service manager was putting systems and processes in place to improve this aspect of the service and its organisation. The service manager confirmed they were working to improve this essential aspect monitoring the service for people.

Although staff we spoke with told us when they received supervision, they found it useful, an audit undertaken in April 2018 showed only 43% of staff had received up to date supervision from their line managers. This meant there was a lack of oversight from the management team in relation to staff practices and performance. We discussed this with the service manager who told us they had changed the structure of the teams to support this area and this should result in all staff receiving supervisions on a regular basis in the near future.

However, staff we spoke with told us there was an open culture where they felt able to raise any concerns they may have. They also told us they could make suggestions and be honest about any mistakes that may have been made. Staff worked in teams and told us they knew who their line managers were and felt they got the support they needed from them. We saw there was a care coordinator who managed different geographical areas and they line managed the staff in that area. Staff also told us there was always a manager on call so they could ring for help and advice out of normal office hours.

Staff we spoke with told us they were happy working at the service they told us the management team

worked with them to get their work life balance right. One staff member said, "I enjoy working for the company they do their best to get your time off when you need it."

The management team also used audits to assess and monitor the quality of the service provided. We saw completed audits relating to areas such as care plans, daily logs and medicine management. For example, we spoke with the Quality Monitoring Officer who undertakes regular audits of the completed Medicine Administration Records (MAR) sheets and daily records staff complete to show what care has been given to a person. They told us when they found a gap in the MAR they checked the person's daily log to see if the care staff had recorded the administration in the log and if not they identified which care staff had made the visit. They said that depending on the frequency of errors, the care staff might have a medicines themed supervision meeting, or a competency assessment or ask them to attend "Impact and Consequence" training for medicines. This showed systems were in place to record and analyse adverse incidents with the aim of identifying strategies for minimising the risks. This showed that the provider was proactive in developing the quality of the service.

People we spoke with told us they had the opportunity to express their views about the service. One person said, "They do it on the phone, ring me and ask me questions." In addition, another person said, "They (staff) usually bring a questionnaire with them for me to fill in." The majority of people felt their views were listened to and resulted in them receiving the care they wanted from the service.

The service manager and their team worked to look at ways they could improve the service for people in their care. For example, the service manager had recognised that staff had not been receiving the support they needed over the preceding months and had altered the structure of the management team to ensure this was addressed. They were amending the team leader role so there was more oversight of staff working in people's home. The provider had also introduced a set of pocket information cards for staff that gave them brief information on essential aspects of care that may be provided such as preventing falls, helping people prevent fire in their home or managing the risks of choking. The introduction of these initiatives shows the service manager and provider's commitment to improving care in the service.