Nestor Primecare Services Limited

Allied Healthcare Liphook

Inspection report

Oak Cottage,13 The Square, Liphook
Hampshire. GU30 7AB
Tel: 01428 729811
Website:www.alliedhealthcare.com

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Ratings

Overall rating for this service	Requires Improvement
Is the service safe?	Requires Improvement
Is the service effective?	Good
Is the service caring?	Good
Is the service responsive?	Requires Improvement
Is the service well-led?	Good

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 gave the provider 48 hours' notice of the inspection. The inspection was announced in order to ensure that the people we needed to talk to were available. Allied Healthcare Liphook is a care agency which provides support to people in their own homes. The service offers assistance with personal care and provides respite and live in care to adults and older people between the ages of 18 – 65 years. Some of the people using the service were living with dementia or have chronic disabilities. The agency operates in north and east Hampshire, Surrey and parts of West Sussex. At the time of the inspection, the service was providing care and support to 125 people.

There is a registered manager at Allied Healthcare Liphook, but they were not available during our inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

Summary of findings

There was a risk that people's rights under the relevant legislation were not being upheld by the service as the legal protections for people lacking mental capacity were not being fully used. This was because mental capacity assessments were not always undertaken to establish if a person was able to make decisions about their care and welfare. This was the case in four of the seven care records we viewed. There was also no appropriate screening tool to assist staff in reaching a decision as to whether people lacked mental capacity in relation to specific decisions about their care. Staff did not demonstrate an understanding of Mental Capacity Act 2005 (MCA) and they told us they had not received training about the (MCA). This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of the report.

During our visits to people in their homes, we saw care workers providing personalised care which was responsive to people needs. However we felt that aspects of the care records could be improved further to help avoid the risk that staff might not have all of the information they needed to deliver responsive care.

People told us that they felt safe and secure when being supported by care workers. Staff told us about how they would recognise and respond to abuse and they understood their responsibility to report any concerns to their management team. Staff were aware of the importance of disclosing concerns about poor practice or abuse and were informed about the organisation's whistleblowing policy.

There were enough staff to ensure that people received a safe service. Recruitment and retention of staff was an on-going challenge but measures were in place to address this. Safe recruitment practices and appropriate pre-employment checks were completed prior to new staff starting at the service.

People told us the care workers provided them with effective support. One person said, "They do everything I want and ask if there is anything extra I need." We observed care and support being delivered in line with people's care plans.

Staff were supported to develop their skills and knowledge through a programme of induction and training which helped them to carry out their roles and responsibilities effectively. One person said, "They cope very well with my disability and I am so grateful for their help." Another person said, "They seem to be well trained."

Staff received training on effectively supporting people to eat and drink as part of their induction with the organisation and were aware of the dangers of poor diet and lack of hydration.

Staff had forged meaningful relationships with the people they supported. We observed interactions between staff and people which were kind and caring. People we spoke with were positive about the care and support they received from staff and told us they were treated kindly, and with dignity and respect. One person told us the care workers were, "Kind and caring." Another person said, "I'm really very lucky with my helpers, they do all sorts of things for me, I do appreciate them."

People were supported to express their views and were involved in decisions about their care. People were also encouraged to share how they felt about receiving support and what they wanted their care to achieve. The information in care plans also provided guidance for staff on how to encourage people to retain as much independence as possible.

People knew how to make a complaint and information about the complaints procedure was included in the service user guide which was in the homes of each of the people we visited. People were confident that any complaints would be taken seriously and action would be taken by the service. We looked at the complaints records and saw that a clear procedure was being followed to fully investigate any concerns that were raised.

People felt the management team were approachable and told us the service appeared to be well run. There was a registered manager in post and most of the staff told us they felt supported by their management team. They told us they felt the management was approachable and effective.

There were systems in place to monitor and improve the quality of the service. People and staff were encouraged to say what they thought about the service and the provider used this feedback to monitor quality and plan improvements to the service.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Mental capacity assessments were not always undertaken to establish if a person was able to make decisions about their care and welfare. Staff did not demonstrate an understanding of their responsibilities under Mental Capacity Act, 2005 (MCA). Staff had not received any training in this area.

People told us they felt safe when staff visited them in their homes. Staff had a good understanding about the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place.

There were enough staff to ensure that people received a safe service. Recruitment practices were safe and relevant checks had been completed before staff worked unsupervised with vulnerable people.

Is the service effective?

Good

The service was effective.

People felt their care workers were well trained and understood how to support them. There was a training programme in place which helped staff to perform their role effectively.

People were provided with appropriate support to eat and drink in line with their personal preferences.

People's health was regularly monitored to identify any changes that might require additional support or interventions from healthcare professionals.

Is the service caring?

Good

The service was caring

Staff treated people with, kindness, dignity and respect. People we spoke with were positive about the care and the support they received and told us they enjoyed the visits from their care workers.

We observed interactions between staff and people which were kind and respectful. The care workers had developed meaningful relationships with those they cared for.

Is the service responsive?

Requires Improvement

The service was not always responsive

We saw care workers providing personalised care which was responsive to people needs. However we felt that aspects of the care records could be improved further to help avoid the risk that staff might not have all of the information they needed to deliver responsive care and meet people's needs.

Summary of findings

People had been involved in drawing up their care plans and these contained information about people's choices and preferences.

Clear procedures were being followed to fully investigate any concerns that were raised. The records of how complaints were dealt with were comprehensive and showed each was thoroughly investigated and appropriate actions taken.

Is the service well-led?

Good

The service was well led.

People felt the management team were approachable and told us the service appeared to be well run.

There was a registered manager in post and most of the staff told us they felt supported by their management team. They told us they felt the management was approachable and effective.

The service had a range of quality monitoring processes in place and regularly sought feedback from people and staff and used this to monitor quality and plan improvements to the service.

Allied Healthcare Liphook

Detailed findings

Background to this inspection

We inspected on the 28 July 2014. We told the provider two days before our visit that we would be coming. The inspection team consisted of an inspector and an expert by experience who had experience of using a range of health and social care services. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. The Expert by Experience gathered information from people who used the service by speaking with them on the telephone.

Before the inspection, we reviewed all the information we held about the service including previous inspection reports and notifications received by the Care Quality Commission. A notification is where the registered manager informs us about important issues and events which have happened at the 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 used this information to help us decide what areas to focus on during our inspection.

We visited the offices of Allied Healthcare Liphook where we spoke with six care workers, a care supervisor and a care coordinator. We also spoke with the Regional Care Delivery Director, the Regional Operations Support Manager and a Quality Improvement Auditor. We reviewed the care records of seven people and the records for four staff. We reviewed other records relating to the management of the service. As part of the inspection we spoke with 18 people who used the service and visited four people in their homes. We spoke with them to find out about their experience of receiving care from Allied Healthcare Liphook.

The last inspection of this service was in September 2013 where no concerns were found.

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005(MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014.They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read relation to these topics, however, can be read in the 'Is the service safe' sections of this report.

Requires Improvement

Is the service safe?

Our findings

There was a risk that people's rights under the relevant legislation were not being upheld by the service as the legal protections for people lacking mental capacity were not being used. This was because mental capacity assessments were not always undertaken to establish if a person was able to make decisions about their care and welfare. This was the case in four of the seven care records we viewed. There was also no appropriate screening tool to assist staff in reaching a decision as to whether people lacked mental capacity in relation to specific decisions about their care. Staff did not demonstrate an understanding of their responsibilities under Mental Capacity Act, 2005 (MCA) and had not received any training in this area. This is a breach of Regulation 18 Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of the report.

People told us they felt safe in their home, when care workers visited. One person said, "I have never seen or heard the carers speak to my husband in a derogatory way." We sent 50 questionnaires to people asking them to tell us about the care and support they received from the service; 18 were returned to us. All of the people that had completed the questionnaire said they felt safe from abuse or harm by staff employed by the service.

There was an organisational lead for safeguarding and a 'Safeguarding Adults from Abuse' Policy which provided guidance to staff on their responsibilities in relation to reporting abuse. The 'Safeguarding, Procedures and Guidance' for Hampshire, Surrey and West Sussex County Councils were available within the service and contained relevant information about how to raise safeguarding alerts, including contact details.

The principles of safeguarding people from abuse were covered within the induction of all new staff and was updated every three years. Staff had a good understanding of the signs of abuse and neglect and were aware of what to do if they suspected abuse was taking place.

Steps had been taken to protect people from the risks of financial abuse by putting in place a process to audit and review all financial transactions undertaken by care workers. For example, when a care worker undertook shopping on behalf of a person, a log of the transaction was maintained in the person's care records and the receipts kept. These records were monitored by the office staff so that any concerns or discrepancies could be identified. The organisation had a policy that care workers must not have access to people's banking pin numbers.

The service operated a 'Safeline' which was available 24 hours a day, seven days a week. Staff were able to ring this line and speak with doctors or nurses to gain advice about how to provide safe and professional care. Staff were aware of how to safeguard people through the use of whistle-blowing procedures and told us that they would raise concerns if necessary. There was a whistle-blowing telephone and internet support line that staff could use to raise concerns outside of the organisation.

Records showed that staff had recently contacted the Local Authority regarding a potential safeguarding matter; However the Care Quality Commission (CQC) had not been informed. Organisations are required to notify the CQC without delay of any allegation of abuse. We spoke with the care delivery director about this, they told us they would ensure the relevant notification was sent.

People's records included risk assessments which provided staff with information about the identified risks and the actions they needed to take to minimise the risks. The risk assessments covered tasks such as moving and handling, continence care, risk of falls, behaviour which might challenge and the use of medication. We saw that records were maintained about people's emergency contacts and that each person had been ranked according to their level of risk or need so that judgements could be made about which care visits were the most critical and therefore needed to be covered as a priority.

A clinical assessment tool was used to assess whether due to the complexity of a person's needs, they would benefit from a referral to the organisation's clinical staff. Clinical staff assessed and developed specific care plans to ensure people's complex needs were met safely. However we saw examples where the clinical assessment tool for two people indicated that such a referral should be made, although we could see no evidence that this had been actioned. Whilst we were not able to ascertain that this had resulted in any negative impact on people, it suggested the systems and processes in place to identify and manage people's complex needs were not always being effectively used. This could mean that some risks might not be managed in the most appropriate manner.

Requires Improvement

Is the service safe?

There were enough staff to ensure that people received a safe service. Staffing levels were determined by the number of people using the service and their needs which could fluctuate weekly. The service was led by a registered manager supported by administration staff, two field care supervisors and two care co-ordinators that were responsible for scheduling the care visits. Care was provided by 52 permanent care workers, 16 of whom had started with the service within the last 12 months. People told us that their care visits were always covered but two people did say that the timing of the visit was not always in keeping with their preferences. These two people were clear that this had not had any significant impact on their wellbeing but was more of an inconvenience. Staff also told us that care visits were always covered and that they were happy with the number of hours they worked. The management team told us that recruitment and retention of care staff was an on-going challenge, but that measures were in place to address this. This included the introduction of some fixed hour contracts and improved induction and mentoring of new staff.

Recruitment and induction practices were safe and relevant checks had been completed before staff worked unsupervised. These included identity and criminal records checks. References were obtained as satisfactory proof employees conduct in previous health and social care employment Staff confirmed that they had completed an application form and had a formal interview as part of their recruitment. These checks helped to ensure that only suitable people were employed by the service.

Good

Is the service effective?

Our findings

People felt their care workers were well trained and understood how to support them. One person said, "They cope very well with my disability and I am so grateful for their help." Another person said, "They seem to be well trained." Our observations during visits to people in their homes indicated that staff had the skills and knowledge to effectively meet their needs. Of the 18 people who completed the Care Quality Commission questionnaire 94% said they were happy with the care and support provided by the service.

Staff had undertaken a thorough induction which helped to ensure they had the necessary skills and knowledge to effectively meet people's needs. This had recently been updated to include a 'core skills' module which helped new care workers to understand early on about the demands and expectations of the caring role. Training was undertaken in a range of areas such as moving and positioning, management of medicines, principles of safeguarding, dementia awareness and first aid.

There was a training programme in place which helped staff to perform their role effectively. The organisation benefited from having its own training room with facilities and an internal training team and clinical specialists who were able to deliver training on specific subjects such as catheter care or specialist feeding regimes. Staff told us that they enjoyed their job and felt well supported in their role. Records showed that most staff were receiving regular supervision in line with the organisation's supervision policy and also received an annual appraisal. This meant that staff received appropriate professional development which helped to understand their role and responsibilities.

People were provided with appropriate support to eat and drink in line with their personal preferences. Staff received training on effectively supporting people to eat and drink. Staff were aware of the dangers of poor diet and lack of hydration and were able to describe in detail the signs and symptoms that might indicate a person was not having sufficient food and fluids. Each person had a nutritional screening risk assessment. This considered issues such as whether the person was known to be at risk of weight loss or had problems swallowing or digesting foods. Staff told us they had been reminded of the importance of encouraging people to take extra fluids during the recent hot weather and we saw that this happened in practice during our visits to people in their homes. Staff told us they were mindful of the need to support people to have a healthy and balanced diet. We observed that care workers were aware of the need to offer people food in keeping with the person's preferences.

Care plans provided information about people's preferences in relation to food. For example one care plan stated, 'fruit to be cut up and yoghurt put on top, tea should be strong with one sugar.' At lunch the care plan recorded that the person liked to take a glass of sherry with their meal. In another person's plan it recorded which tea cup the person liked to drink from. During our visits to people in their homes, we observed that care workers were aware of people's dietary preferences. Care workers told us that where people were known to be at risk of not taking adequate food and fluids, charts were used to record what the person ate and drank. We were told that any concerns were then shared with the management team so that judgements could be reached about this could be shared with relevant professionals. This all helped to ensure the people were protected from the risks associated with poor nutrition and hydration.

People were supported to maintain good health. Care workers kept a record of the support undertaken on each visit and made other relevant observations about the person's health and wellbeing. Concerns about people's wellbeing were shared with office staff or the on call service so that action could be taken to contact family members or health care professionals such as Doctors and community nurses.

There was an effective system in place to share key information about the person's needs and medical history with ward staff upon admission to hospital. This helped to ensure care workers were kept informed about changes to a person's needs or new medications following discharge from hospital. This meant that the service could ensure that staff received all the necessary training required, for example, in response to changes in the person's mobility or any new equipment being used following their return home.

Good

Is the service caring?

Our findings

People told us staff treated them kindly, with dignity and respect. They were positive about their care and the support they received from staff. One person said, "The care workers are marvellous." Another person said, "We have a very nice carer, it is a perfect service, they are helpful." A third person said, "I'm really very lucky with my helpers, they do all sorts of things for me, I do appreciate them." Another person told us, "It was nice to see a friendly face."

Similar comments were reflected in the organisation's compliments records. One person had recently commented that their care worker was their "Little ray of sunshine….her guardian angel." Another person had stated, "The carers are wonderful, they treat me like the queen."

All of the people that had completed the Care Quality Commission questionnaire said their care workers were kind and caring and treated them with dignity and respect.

Staff had a good understanding of how to ensure people were respected and their dignity maintained. This included asking people for their consent before providing care and by ensuring that doors and curtains were drawn when performing personal care tasks. We saw that care staff supported people with personal care in a way which promoted their dignity and respect. For example, we saw care workers asking people where they would like their care to be undertaken so that no one else was able to see.

The care workers had developed meaningful relationships with those they cared for. We observed that care workers treated people in a manner which conveyed that they felt the person mattered. For example, a care worker, spent time actually showing a person each of the options she could choose for her lunch. They gave them time to make their choice and used just the right amount of friendly chat which appeared to help the person feel comfortable and relaxed. A care worker told us "You don't treat people like it's just a job." Another care worker said, "Just doing that extra thing that puts a smile on their face makes them feel better and me, there is nothing better."

The induction processes helped to ensure that care workers adopted good practices at the start of their employment. We saw that staff had a good rapport with people and we observed interactions that were kind and respectful. Staff spoke with them about the things that were meaningful to them and people seemed to enjoy the company of their care workers.

People were supported to express their views and were involved in decisions about their care. Care plans contained information about which people the individual wanted to be involved in their care and support. One person told us how they and their GP had been fully involved in this process. People were also encouraged to share how they felt about receiving support and what they wanted their care to achieve. For example, we saw in one person's care records that their expected outcomes were that they would be supported to maintain a good standard of hygiene and have their dignity maintained.

Care plans were written in a manner that encouraged staff to enable people to express their choices about what they would like to eat and how and where their care was provided. One person's care plan stated "Please ask me about clothes, I will be able to tell the carer what I would like to wear." The information in care plans also provided clear guidance for staff on how to encourage people to retain as much independence as possible. For example, one person's care plan stated, "I am very independent, I will try and hold on to my independence for as long as possible so please don't just do things for me." All of the people that had completed the Care Quality Commission questionnaire said the care they received helped them to be as independent as possible.

Requires Improvement

Is the service responsive?

Our findings

Feedback from people about the quality of the service was mostly positive and they were pleased with the care and support they received. One person told us, "I am pleased that when there are any changes in my care and health needs, they are passed onto carers."

During our visits to people in their homes, we saw care workers providing personalised care which was responsive to people needs. For example, we saw that one person had been feeling unwell during the care workers previous visit. The care worker had contacted the office to report this. They had then phoned to check if the person would like their doctor to be called. The person told us, "They [care worker] was so nice to me…they made me comfortable in bed".

An assessment of people's needs had been undertaken when they started to use the service and the information gathered was used to produce care plans which informed staff on how to deliver people's care and respond to their needs. The care plan specified what support the care workers would provide. For example, plans contained details about how people should be assisted with their personal care, prompted with their medication and how their moving and positioning should be managed. Care plans were mainly written in a task orientated style. However, they did contain some details about people's personal preferences, such as what activities they liked to do. Where able, people were asked to consent to their care and support and to confirm that they had contributed to the development of their care plan. Of the people that had completed the Care Quality Commission questionnaire 89% said they had been involved in planning their care and support.

We did see some examples, where the information in people's care plans could be improved to ensure that staff always had relevant information about the person's current needs. For example, whilst the care plan for one person contained some guidance about the interventions or techniques staff could use to respond to aspects of their behaviour which could be challenging, we felt this could be more detailed. During a visit to a person's home, we saw that staff were applying creams to treat an outbreak of shingles, but this was not mentioned in the person's care plan. Two staff told us that they felt the care plans could provide more information about people's personal histories and life experiences, which would support them to better understand the person and what was important to them. We did not find any evidence to indicate that these people had received unsatisfactory care as a result of the omissions in their care plans. Staff told us that they were able generally kept well informed about changes to people's needs through the use of phone calls and message alerts. This reduced the risks of staff not accessing the most up to date information about people's care and therefore not responding to their current needs.

The majority of people told us they received care at a time which suited them and their care workers stayed the allocated amount of time. However, we did find two examples where people were not receiving their care at a time of their choosing. One of these people said, "They [care workers] come when they are free." We looked at this person's schedule for the week and saw that the start time of their visits varied between 10.30am and 12pm. They told us that they preferred to receive their care at 10am. Staff told us that they usually managed to arrive on time to visit people, but could sometimes be late for their next call due to lack of adequate travelling time being calculated when the roster was drafted. They told us, whilst the office staff were generally very good and tried to address this, they felt that the allocation of travelling time was an aspect of the service which could be improved to ensure that care was being delivered in line with peoples wishes and preferences.

People could express a preference for which staff did or did not undertake their care and support. People told us that they usually received their care from a consistent team of carers. However, two people did comment that they were times when new carers were sent and that this could be a less positive experience. For example, one person said, "The odd carer is not as good when they are covering for my usual lady." A second person told us that their care workers were "Much the same group, but occasionally there is someone new and you have to show them what to do. All of the staff we spoke with told us that additional staff would help to ensure that they were able to deliver consistent care to people. We were aware that the registered manager had identified that the provision of consistent care workers was an area where improvements were needed. The provider information return highlighted

Requires Improvement

Is the service responsive?

that the service hoped to make improvements in this area by increasing the number of care visits which were 'templated' or allocated to a specific care worker each week.

There were arrangements in place for dealing with foreseeable emergencies. There was written guidance for staff to follow if there was no reply at a persons' address, or what action should be taken in the event of an accident. The provider also had a severe weather emergency plan which outlined how people who used the service would receive care in such an event. Staff told us that the on call arrangements operated by the service worked well and that they felt safe and well supported when working independently in people's homes. This helped to ensure that they were able to respond effectively in to emergencies affecting people who used the service.

Each person had a 'Service User Guide' which described how complaints would be dealt with by the organisation and how to raise concerns with the Care Quality Commission or the local authority. People were confident that any complaints would be taken seriously and action taken by the service. One person told us, "I have had reason to complain when the carers have not been effective, but they did act." Another person said, "We had a bit of a problem with a replacement carer, but this was sorted out." We looked at the complaints records and saw that a clear procedure was being followed to fully investigate any concerns that were raised. The records of how complaints were dealt with were comprehensive and showed each was thoroughly investigated and that appropriate actions had been taken to address the concerns.

Good

Is the service well-led?

Our findings

People felt the management team were approachable and told us they were comfortable contacting them with any concerns. One person said, "The office always gets back to me…..they do try and avoid sending me new carers and usually tell me if my carer is going to be late".

People were offered opportunities to comment on the service they received by completing satisfaction surveys. We saw that between June 2012 and May 2014, 52 people returned satisfaction surveys. The responses indicated that people felt that the organisation was improving the way in which it dealt with problems about their care and 84% of people who took part in the survey said they would be extremely likely or likely to recommend the service to friends and family. Areas which had seen a decline in performance were care workers coming at a time that suited people. In response to the survey the organisation had developed an action plan to achieve the necessary improvements.

The service promoted a positive culture which helped to motivate staff to deliver a good quality of service. Staff were also able to make suggestions for improvements to the service by completing satisfaction surveys on a quarterly basis. The responses to the most recent survey had however been analysed on a county wide basis and not by individual location. Staff told us they felt the management was approachable and effective. Comments included, "They [office staff] have all been care workers, they understand, they are approachable." In relation to the Registered Manager they said, "I know if I needed them, they would be available. "Another care worker said, "There is never any negativity about raising concerns; you are always encouraged to come into the office." Another care worker told us that they felt morale was good within the branch.

Regular team meetings were held which were an opportunity for staff to discuss ways in which the safety and quality of the service could be improved. For example the organisation's whistle-blowing line was promoted. Staff were encouraged to consider further opportunities for training such as the Health and Social Care Apprenticeship and information was provided about the direction, vision and values of the organisation.

In order to develop and retain care staff, the manager was introducing the use of "care coaches" whose role was to provide training, mentorship and act as a role model for new staff so that they are able to develop their confidence and competence as care workers. New care workers were provided with formal feedback, by both senior staff and people, about their performance following their first shift.

There were clear care governance and quality assurance systems in place. Every three months an internal "compliance audit" was undertaken which was a comprehensive review of the performance of the service in relation to a number of areas such as the effectiveness of people's records and the completeness of employees files. Staff skills and knowledge were tested through the use of scenarios. Management undertook spot checks of care workers' practice on a regular basis to ensure that they were supporting people in line with their care plan and following correct moving and handling and infection control procedures. Spot checks are visits made without warning to randomly selected care workers to monitor their practice. Records of these spot checks were on staff files and we saw that they were used as a developmental and learning tool.

Reports from a computerised call monitoring system assessed whether calls were being completed on time and that care workers were staying the allocated length of time. This system also provided real time alerts in the event that a call was missed or was late allowing office staff to make alternative arrangements. A "compliance recording tool" linked to staff rostering prevented staff being allocated to care visits if their training or supervision was not up to date.

The management team encouraged and supported the personal development of staff. There were a range of training opportunities provided and staff were able to express an interest in doing further learning through the Qualifications and Credit Framework (QCF). The QCF is a flexible route which allows care workers to undertake nationally recognised qualifications which demonstrate their competence in health and social care. The Registered Manager had taken steps to recognise and value the skills of its carers by instigating 'Carer of the Month'. Each month a care worker was chosen based on compliments from people or colleagues to be 'Carer of the Month'.

Learning from incidents and accidents took place and action was taken to help protect people from harm. Incidents such as missed or late calls or concerns about

Good

Is the service well-led?

people's welfare were logged on an electronic data base and investigated by office staff who made a note of the learning achieved as a result of the incident. Where required, action had been taken to help prevent similar incidents happening. All incidents were reviewed by the Regional Care Delivery Director to ensure that they had been resolved appropriately.

Other reporting mechanisms were used to provide information about issues such as the number of calls not yet allocated to care staff and where improvements were needed to the running of the service. Reports were also available which assisted the service reaching realistic judgements about where and at which times of the day, there was room for expansion in terms of taking on new care and support packages. This helped to ensure that governance arrangements were effective and that judgements could be made about the effectiveness, safety and quality of the service.

The registered manager was proactive in looking for ways to continually develop and improve the service. For example, plans were in place for field care supervisors to start undertaking quarterly visits to people to ensure that everything was going well and receive feedback about the care delivery. Other objectives included achieving greater continuity of care for people. To achieve this there was a target of ensuring that 97% of care visits were assigned to regular care workers on a weekly basis.

The organisation was in the process of rolling out 'Early Warning Screening for Home Care'. This utilised a screening tool to help staff spot the early signs of deterioration in a person's health and wellbeing so that timely and appropriate health care interventions could be requested or action taken to safeguard people from abuse. It was hoped that this development would in the future enhance the responsiveness of care received by people using the service.

The regional management team explained that they were exploring how in the future they might use technology such as tablets and smart phones to help provide an increasingly responsive service where the information available to care workers about people's needs was instantly updated. However the management team explained that at present there were a number of challenges to overcome. Recruitment and retention of staff was described as the main challenge and achieving a robust plan to address this was recognised as being key to the effectiveness of the service. A number of initiatives were being put in place to attain this.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment Regulation 18 HSCA 2008 (Regulated Activities) Regulations 2010 Consent to care and treatment. The provider had not made suitable arrangements to make ensure that staff acted in accordance with the legal requirements where people who use the service did not have capacity to consent to care, treatment and support. Regulation 18