Nestor Primecare Services Limited

Allied Healthcare Coventry

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
Is the service effective?	Good
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 22 February 2017 and was announced.

At our last inspection the service was rated as 'Requires Improvement' and was in breach of Regulation 18 (Staffing) of the Health and Social Care Act, Regulated Activity Regulations 2014.

During this visit we found improvements had been made and the service was no longer in breach of the Regulation.

Allied Healthcare Coventry is a domiciliary care service providing personal care to people who live in their own home. At the time of our visit the service had a team of 49 care workers providing support to 123 people.

The service had a registered manager who worked at the service 2.5 days a week. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

At our last inspection people were not receiving their care calls on time and staff rushed their care calls because there were not enough staff to support the number of people who needed care. Since then, the provider has improved its recruitment and retention of staff and there were enough staff on duty to meet people's needs.

At our last inspection people were not happy with the service's response to concerns or complaints. During this inspection people told us any concerns were responded to quickly by the office staff. The provider monitored any concerns raised to ensure they were managed in line with their policy and procedure.

At our last inspection people did not feel there was good communication between the care workers and office management, and staff morale was low. During this inspection we found communication had improved, and the provider had introduced a range of measures to improve staff morale and to show they valued their staff.

People received care from staff they were familiar with and who took their time to provide the care they needed. Staff mostly told us they had enough time to travel from one person's home to another so they could get to their calls at the expected time.

People felt safe with staff who supported them, and staff recruitment procedures reduced the risks of the service employing unsuitable care workers. Medicines were managed safely so people received their medicines as prescribed.

Staff received good training and support from the provider. The management and staff had a good understanding of the principles of the Mental Capacity Act, and made decisions in people's best interests when they did not have capacity to make informed decisions for themselves.

People felt staff knew how to provide care for them and told us staff were very caring. Staff treated people with dignity, respected their property, and ensured privacy when undertaking personal care. Staff quickly identified if people's health care needs changed and liaised with the right health care professional to support the person.

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.

There were enough staff to meet people's needs, and people received care from staff they were familiar with. Staff recruitment procedures reduced the risk of employing unsuitable staff. The risks related to people's care were understood and minimised through appropriate risk assessments and care planning. Staff understood how to safeguard people and protect them from harm.

Is the service effective?

Good

The service was effective.

People received the food and drink they needed, and staff liaised well with other healthcare professionals if they noticed any changes in a person's health. Staff received good training and support to help them with their work and to meet people's needs effectively. The service understood and worked within the principles of the Mental Capacity Act.

Is the service caring?

Good

The service was caring.

People found staff very supportive and caring. People told us staff treated them with dignity and respect. Staff ensured people's privacy was supported when undertaking personal care.

Is the service responsive?

Good

The service was responsive.

Staff understood people's likes and dislikes and tailored care to take into account their expressed preferences. People were involved in planning their care and reviews of care. Concerns or complaints were dealt with quickly and in line with the organisation's complaints policy and procedure.

Is the service well-led?

Good

The service was well-led.

The office team worked well together to support their customers and the team of care workers. The provider had introduced incentives to reward staff and to show their appreciation for the work they did. The provider had procedures and checks to monitor the quality of service and to address any shortfalls identified.

Allied Healthcare Coventry

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 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.

The inspection took place on 22 February 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to be sure the registered manager was available on the day of our visit, and could set up appointments in advance for us to talk with their staff and people who used the services.

The inspection team consisted of one 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.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events, which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services, which are paid for by the local authority. The local authority commissioner had no concerns about this service.

We spoke with nine people, and two relatives of people who used the service. We spoke with five care staff, two office staff and the registered manager.

We looked at four care records, three recruitment records, training records, medicine records and checks the registered manager and provider undertook to ensure a quality service was delivered to people.

Good

Is the service safe?

Our findings

We asked people who used the service whether they felt safe with the staff who provided care to them. All people and relatives we spoke with told us they felt safe. Typical responses from people to our question were, "Yes, very safe, definitely. They are just so good with me," and, "I most certainly do (feel safe). They are all so nice." A relative told us, "Oh yes, quite safe for them to be with her. She can speak her mind and would say if something wasn't right."

At our previous inspection the service was found in breach of Regulation 18 (Staffing) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This was because there were not enough staff to attend to all of the scheduled calls; people did not always receive a service from staff they were familiar with; and staff did not always stay the amount of time they were contracted to because they were in a rush to get to the next person.

After our previous inspection visit, the provider sent us an 'action plan' detailing how they were going to improve the staffing arrangements at the service. During this inspection we looked to see whether staffing had improved.

We found the organisation had improved its recruitment and retention of staff. This time people told us staff usually attended their calls on time. All people we spoke with told us if staff were late they would contact them to let them know, but this was usually to do with traffic conditions. For example, "They are normally here on time but they do call if they have got held up for any reason."

We asked if people felt care workers rushed their call so they could attend another appointment, or, whether they felt staff worked at their preferred pace. Of the 11 people and relatives we spoke with, only one spoke of occasionally feeling rushed by one of their team of care workers, but then went on to tell us their care workers did, "A damn good job" and they, " had a good team." All other people we spoke with said they had not been rushed when care was provided. For example people said, "I have two calls a day, they don't rush and stay the time." And, "They don't rush and always find time for a chat."

We looked at the call schedules of two members of staff. Whilst some of the travel times were short, we were re-assured it was because people lived close by and it would not take staff long to travel from one person to another. Staff' were now paid for their travel time and most felt there was enough time to get to the next person's home. Most staff we spoke with told us they had sufficient time to undertake their responsibilities, at the person's preferred pace.

The majority of people who used the service had their care calls paid for by the local authority. As part of the service's contract with the local authority, care call times were monitored to check staff stayed the expected length of time. This meant when staff arrived at the person's home, they had to phone a number confirming they had arrived, and phoned to confirm the time of leaving. These calls were not charged to the person and meant the service, and the local authority, were able to check that staff attended the calls at the time expected and stayed the required length of time. The local authority had no concerns about the service

provided.

The registered manager told us they had improved their staff recruitment procedures and now staff wanted to stay with the organisation. They told us previously high sickness rates put pressure on staff to take on more calls, and this led to some staff leaving. They told us the organisation had improved how it managed staff sickness and this had seen levels of staff sickness fall. They said staff were also offered a better pay and reward system, with staff offered guaranteed hours of work once they had completed their probationary period. One member of staff told us, "Retention has got a lot better. In the last couple of years, I have seen more people [staff] stay than go."

This meant the service was no longer in breach of the Regulation.

New care workers were also provided with a 'safety starter pack'. This included a torch, and pin watch, a mobile phone charger, an attack alarm, a pen and a diary. This was to promote staff safety but to also show staff they were valued by the organisation.

People were protected by the provider's recruitment practices. The provider obtained references from previous employers and checked whether the Disclosure and Barring Service (DBS) had any information about them. The DBS is a national agency that keeps records of criminal convictions. It was previously known as the Criminal Records Bureau (CRB). They also checked prospective staff had the right to work in the UK.

The provider used a 'key safe' system when people who used their service were not able to open their front door to let staff in. A key was held in a secure box outside of their home which staff accessed via a confidential code. We asked people whether this system worked. Many of the people we spoke with told us that whilst it was in place, they had not needed to use it because relatives were often around to open the door to staff. For those who had used it, they told us it worked well. One person said, "They use it all the time and yes, make sure everything is closed when they go. I have never had any trouble with them using it." Another said, "I have a key box but my door is usually open for them. They lock up when they go." The registered manager told us if a member of staff left the company, they would change the key codes of the houses they visited to ensure people remained safe.

Staff had a good understanding of the risks related to people's care and ensured these were managed to support people safely. Records confirmed risk assessments had been completed and care was planned to take these into account and minimise risk. For example, one person was not able to move their body on their own, and when they were in bed they were at high risk of their skin being damaged. The person's skin care plan informed staff to "Take the time to ensure [person] is sitting on crease free surfaces." This was because creases in bedding could rub against the skin and cause skin damage.

The provider had an out of hours' service for people to use at the week-ends or in the evenings if they had any concerns or queries about their care. The out of hours cover was provided by a central 'hub' covering a number of Allied healthcare services. They dealt with the majority of calls, only referring them onto the local branch team if they could not answer the query. The office staff in Coventry had a rota for managing any calls made to the local service from the hub. The office staff were made aware of any calls to the out of hours service the following morning for them to follow up if required.

The registered manager had a good understanding of their responsibilities to identify and report potential abuse of people to the local authority. Staff also knew their responsibilities to report any witnessed abuse or allegations of abuse to their senior. They told us they had received training to help them safeguard people

from harm. We gave staff different scenarios where people might be placed at harm and asked them what they would do. For each of the safeguarding scenarios staff responded that they would contact the office to inform them of their concerns, and they would expect the office staff to act on this.

The handbook provided to all new staff gave staff information about safeguarding, and also informed staff of what to do if they had any concerns about other staff's dishonesty or illegal activity. If staff did not feel able to speak with the branch team, there was a 'whistleblowing' email address and telephone number where their concerns could be shared with the separate whistleblowing team.

Staff administered and prompted people to take their medicines safely. Staff told us they had undertaken training to administer medicines, and as well as training, the office staff checked at least once a year, to ensure they remained competent in administering people's medicines safely.
The registered manager told us if concerns were raised about staffs practice either through the medicine audits they undertook, or through competency checks, the staff member would not be able to administer medicines until they had undergone further training and had satisfied the manager they were competent to carry on.

Most people we spoke with administered their own medicines, however a relative told us their relation had to have their medicines at a specific time each day, and after they had eaten. They told us staff made sure they did this. They went on to say, "The BBC should be there at 6pm to see what they do," this was because they were so pleased with the care and attention staff paid to ensuring their relation got their medicines as prescribed.

Good

Is the service effective?

Our findings

We asked people if staff supported them with their meals and drinks. Most people we spoke with either made their own food or used pre-packaged meals, but some people were supported by staff to make some of their meals and provide them with drinks. For example, people told us, "They just call in and get me my lunch at lunchtime and make me a drink. They do a microwave meal for me." And "Well I get my own breakfast and have [a prepared meal] I do in the microwave for lunch. They do come in and get my tea for me though." One person told us the staff were flexible and whilst they were not expected to get them food and drink, if they were ill, they would help them with this by making them breakfast and preparing a sandwich for their lunch.

The registered manager told us where people were at risk because they were not eating or drinking well, they made sure the relevant family members and professionals were made aware of their concerns. One of the care records we looked at demonstrated this. Staff had become concerned about a person's loss of weight and their reluctance to eat. They had contacted the office team to inform them of their concerns and the person's GP had been contacted. This led to the person being prescribed a milkshake style nutritional supplement to provide them with the nutrients they needed to stay well. Where people's dietary intake required monitoring, the service used food and fluid charts to check whether people were receiving the right amount of food and drink to support their well-being.

The service supported some people who lived with dementia with their eating and drinking. The care plans identified how the person's dementia impacted on their eating and detailed how staff needed to respond. For example one person's care plan said, "I need the carer to sit with me and make sure I eat the food, as although I eat independently, I will forget and put the tray down."

We saw that care staff supported some people who had their meals via a tube inserted into their stomach (PEG feed). Care plans provided staff with detailed information about how these should be used and staff were trained to deliver the 'feeds' through the tube safely.

Care staff knew to contact the office if they had other concerns about a person's health and the office staff would contact the relevant healthcare professional. People and relatives told us they either had experience of staff doing this or were confident staff would do so. One person told us, "[The care worker] has called the doctor before. If she thinks anything is wrong she will call him," another said, "They are all wonderful, they would definitely call for help if I was poorly."

Through looking at care records and speaking with staff, we found the service involved a range of health and social care professionals. Social care professionals were contacted when the service felt the person's needs had changed and they could no longer provide care safely within the timescales originally set out in the care plan. Healthcare professionals such as occupational therapists, district nurses and the person's GP were contacted if there were concerns which required their professional guidance.

Staff also knew when to contact emergency services. We spoke with a staff member who told us they had

been working regularly with a person who used the service. They were familiar with the person and they felt the person 'wasn't right' when they visited them. They discussed this with office staff and decided to call for an ambulance. The paramedics, after undertaking initial checks on the person, agreed the person was not well and needed to go to hospital.

The organisation provided staff with an induction to the service and training to ensure they could meet people's health and social care needs. A member of staff new to the service told us the training was, "Really informative and delivered in a fantastic way which helped staff to understand what was being taught." Other staff confirmed training was, "Very good."

New staff received training considered 'mandatory' by the sector. This included moving people safely, infection control and safeguarding people training. They were also provided with training to support people's specific needs. For example, staff' were trained to use a PEG (Percutaneous endoscopic gastrostomy) because some people required support with one. A member of staff told us, "If I want to do any other training, for example, stoma training, they would put me on it."

Once staff had received their training they were then mentored by a 'care coach.' Care coaches were members of care staff who worked with new staff until new staff felt confident to work on their own. A care coach told us they could spend up to 40 hours with a new member of staff. They tried to ensure the staff member went on a variety of calls with them to support them in their learning.

Each care coach completed a 'coaching passport' which confirmed they had observed the new member of staff satisfactorily undertake various tasks such as supporting a person to eat, supporting mobility and movement, and supporting washing and dressing. The care coach we spoke with felt this had improved staff retention because it gave staff confidence in their work. It also gave them a named worker they could phone if they were unsure about anything and needed advice.

The care coaching was part of assessing staff for the Care Certificate. The Care Certificate is expected to help new members of staff develop and demonstrate key skills, knowledge, values and behaviours, enabling them to provide people with safe, effective, compassionate, high-quality care. A new member of staff confirmed to us they had received the Care Certificate at the end of their probationary period.

The service had a system of checks, and meetings with staff to ensure staff undertook their roles effectively and received the support they required. The field supervisor carried out unannounced checks on staff twice a year. The checks looked at areas such as safety, medicines administration, staff behaviour, and the use of equipment. The majority of people we spoke with confirmed they had seen these unannounced checks take place in their home.

Staff also met with their manager twice a year for formal supervision meetings (meetings where issues or concerns about work, and staff development can be raised) and appraisals of their work performance. Staff told us they were able to contact the office at any time they had a concern and office staff would be available to talk to them.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. The registered manager informed us there was nobody they supported who was being deprived of their liberty within their home environment.

We checked whether staff understood the MCA. Staff told us they had received training to help them understand the Act, and we saw Allied healthcare had a comprehensive policy on Mental Capacity which gave staff clear guidance on what the principles of the Act were, and how staff should assess whether people had the capacity to give consent to different aspects of care.

Care records showed where a person lacked capacity to make a decision, a best interests decision had been made on their behalf. Staff told us if they started working with a person who had capacity to make decisions, but they were getting concerned the person's mental capacity was changing and they were struggling to retain information, they would contact the office for an updated assessment.

Good

Is the service caring?

Our findings

People and relatives told us they were treated with kindness and had developed positive relationships with staff. One person told us, "I would describe the care as excellent." And another said, "I am extremely happy with them."

People who used the service were supported by the same individual member of staff, or team of staff each week, unless staff were absent due to holidays or sickness. This meant staff got to know people well and developed positive relationships with them. A relative told us their relation's care workers were, "A credit to the company." They went on to say, "They really have brought [person's name] around, there have been wonderful improvements due to the carers." Another person told us, "They are wonderful with me and make me feel like I am part of the family."

People told us they felt involved in their care, were listened to by staff, and their views were acted on. One person told us, "Nothing is too much bother for them." Others told us they enjoyed staff' company because they spoke with them and listened to them. For example, one person said, "They are very kind and supportive. We have a good chat and talk about holidays." Another said, "Not half. I do talk a lot, we always have a good natter and if I need anything they see to it."

The care staff we spoke with were caring about the people they supported. One care worker told us, "We provide 'caring' care. We care about people as individuals, and their general welfare." Another care worker told us, "I like to think I do my job properly and look after people how I would like my parents to be looked after." They gave us an example of how, if they realised they had forgotten to give a person a drink they would have to go back because they would not feel they had cared for the person properly.

A care worker who had worked for the company for many years, told us they had built good relationships with people they supported. They explained for them it was important to be able to continue caring for a person who was ill and at the end of life until they passed away. They told us they then felt their job was complete.

All the people we spoke with told us that they felt staff treated them with respect and dignity. One person told us, "They are polite; they ask if anything else needs doing." We asked staff how they demonstrated respect when they were in someone else's home using their facilities and equipment. A member staff told us when they entered a person's home (using a key safe), they would always make sure the person knew they were there by shouting out, "Hello its [name] the carer, would you like me to put the light on for you." They went on to tell us they would always ask permission if they needed to move items and then move them back to the place they were originally before they left the person's home.

Staff told us they maintained a person's privacy when undertaking personal care by, "making sure you close the door so if anyone else is in the property the person isn't being exposed. We also make sure the curtains are closed so privacy is kept." Another member of staff told us when they washed a person they would cover their 'private parts' to preserve their dignity.

One member of staff told us of how they had promoted a person's independence. They worked with a person who lived with dementia. When they first undertook care calls with the person, the person never went out of their house, but through working with the person and gaining their trust, the person was now supported to go out to places they enjoyed such as the local garden centre.

Good

Is the service responsive?

Our findings

Before people were provided with care, the office staff visited the person to discuss what their care needs were and how they would like their care provided. The field care supervisor was responsible for undertaking initial assessments and putting together care plans for staff to work from.

As part of the field care supervisor's work, they spoke with people and their relatives about their personal history and their personal preferences. These were documented in people's care plans so staff could get to know the person they were supporting. For example, one person's notes told us about a shop the person worked in when they were younger, and that the person liked care workers to sing and have a laugh and a joke with them. Staff told us because they saw the same people, they got to know people more over time through talking with them and/or their families. Any important new information was given to the field care supervisor for the care records to be updated.

We found that newer care plans were written from the perspective of the individual person (person-centred), and gave staff a real understanding of how the person wanted to be supported. For example, each care plan identified what was important to the person. One care plan told us it was important that, "Carers talk to me when they are doing personal care." Another care plan written for a person who lived with dementia, informed staff the person would, "Forget through the caring process what has happened. Carers are to constantly provide gentle reminders."

People told us either they, or their relative were fully involved in planning and discussing their care. One person said, "The carer does the care plan with me and [office staff] came out from the office as well." Another told us, "The office staff come out and we do it together." We found that one person who required 24 hour care was involved with the recruitment of the staff who would support them in their home. Allied healthcare undertook the initial interviews to ensure staff had the knowledge and experience to provide care, and then the person made the decision about who they wanted to be in their home based on their personal preferences.

At our last visit, we found two of the six care plans we looked at did not provide up to date information about the person's changed needs. At this visit we found care plans provided up to date information about the person, although one care plan did not have enough information about a person's complex medical conditions and how this might impact on the care provided. The field care supervisor told us this care plan was due to be updated and would ensure the information was included.

The registered manager told us care plans were reviewed once a year unless the person's needs changed and the review would then be brought forward to ensure their new needs were incorporated into the care plans and risk assessments. By looking at records we could see this had happened. We also saw that the field care supervisor had a meeting booked the week of our visit, to discuss the changing needs of a person and to update their care planning.

Office staff wanted the best for people who used the service. If they felt the person's care contract with the

local authority did not give staff sufficient time to meet the person's needs safely or in a person centred way, they worked with the local authority to try to address this and increase the level of funding to provide staff with more time to support the person.

At our last inspection we found people and their relatives were not satisfied with the way complaints to the service were managed. During this visit we checked whether this had improved. We asked people if they had ever had cause to complain about the service. Two people we spoke with had complained. One told us this was because previously they had a member of care staff who was rude to them and rushed them. They went on to tell us they phoned the office to inform them of their experience and, "It was sorted out very quickly." Another said they had problems with the out of hours' service when a care worker did not turn up but this was resolved to their satisfaction. They went on to say, "Any hiccup, I've spoken to [office manager] and she's sorted it." The other people we spoke with told us they had not needed to complain.

The registered manager told us all concerns, whether they were logged through informal telephone discussions with people, or via letters of complaint, were treated as a complaint and responded to as part of their complaints process. We saw a recent complaint had been investigated appropriately and in a timely way.

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Good

Is the service well-led?

Our findings

At our last visit we found improvements were required because of; communication issues between staff, people and the office management; the management of complaints; insufficient staff to meet people's needs leading to people not receiving care at the expected time; and staff feeling rushed when providing care.

During this visit we found improvements had been made. The organisation had improved its staff recruitment procedures and there was now sufficient staff to meet people's needs. They had also looked at how they valued their staff to improve staff retention. Staff were given much more support at induction and in their probationary period to help them in their role as lone care workers. Staff were paid for travel time and provided with guaranteed hours once they had passed their probationary period.

The service showed they valued staff by thanking staff when they had undertaken a good piece of work. A member of staff told us they sometimes got a phone call or a card to say thank you for the work they had done. They went on to say, "It's amazing what that makes you feel like. I was so proud to get a card with a thank you."

Staff were awarded 'Carer of the Month' if they demonstrated they went over and above 'the normal call of duty'. This provided them with a certificate, financial reward of a £20 shopping voucher, and a letter from the Chief Executive Officer. Two of the staff we spoke with had been awarded Carer of the Month. They told us this had meant a lot to them. They said, I do it (care work) because I want to do it, but it was nice they recognised what I was doing. They are a good company." And, "It gives you a boost. It is nice to have a little extra."

Other incentives to value staff included a branch newsletter and a carers' newsletter which was sent out to all Allied Healthcare staff', and a monthly prize draw where care workers could win prizes ranging from a TV, to a holiday.

The office team consisted of three staff. The registered manager spent half the working week at the Coventry office, and the other half at the Leicester office where she was also the registered manager. Her role was to look at compliance, ensure the service was meeting its performance targets, and to support the office staff when necessary. The office care co-ordinator managed staff, ensured the rotas and time sheets went out on time, and made sure training was up to date. The field care supervisor assessed the needs of new people, completed reviews and attended urgent reviews, and undertook the unannounced checks of care workers.

People we spoke with did not know who the registered manager was, but knew the names of the care co-ordinator and the field care supervisor who they had more contact with. Whilst all the office team were seen as supportive, both staff and some of the people we spoke with were very complimentary of the support received from the care co-ordinator. One person told us, "If I am not happy with any of them (care workers) I will phone [care co-ordinator] she will come down on them like a ton of bricks." Another person told us the care co-ordinator was "A very good team leader. She always gives you time and gets a resolution."

Staff told us, "The office staff are very friendly and nice. [The care co-ordinator] is brilliant…I could phone her up and her tone of voice never changes – she is fantastic at her job." Another said, "She's one in a million." They went on to tell us a care worker's client had died and they were really upset, the care co-ordinator went to see them straight away. A third told us the office co-ordinator was "An angel – she is a diamond. When you have someone in the office who listens and cares about you, it makes work so much easier."

The office team were provided with support by the care delivery director and the regional managing director. They looked to make sure the registered manager had undertaken the expected checks, and to provide further guidance and support when necessary.

People and their relatives were asked to give feedback about the quality of the service through quality assurance surveys. Seven of the people we spoke with confirmed they had completed questionnaires asking for their feedback. Feedback was analysed for any trends or patterns in the information received, so the manager could continuously improve the service. Staff were supported to give feedback about the service through engagement at regularly held staff meetings.

The provider completed regular checks to ensure the service was meeting people's needs. These included checks to ensure records were completed in line with company policy, medicine records were accurate, recruitment was safe, and staff attended calls on time. Care records were checked every six months. We found some daily records which had been checked did not meet the company standards of report writing, but had been signed off as acceptable. The registered manager told us in response to this they would bring forward staff training in report writing, and instigate more regular records checks.

The registered manager had when required, submitted notifications to the Care Quality Commission. The provider is legally obliged to send us notifications of incidents, events or changes that happen to the service within a required timescale. This meant we were able to monitor any trends or concerns. The provider also notified us of their office move and applied for a change of registration to ensure they continued to operate within the regulations.