

Bradgate Homecare Limited

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Inspection report

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Ratings

Overall rating for this service

Requires improvement



Is the service safe?

Requires improvement



Is the service effective?

Requires improvement



Is the service caring?

Requires improvement



Is the service responsive?

Requires improvement



Is the service well-led?

Requires improvement



Overall summary

The inspection took place on 19 and 20 November. We returned on 2 December 2015. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available to speak with. At the last inspection in September 2014 we found the provider had not met the regulation relating to management of medicines. At this inspection we found the provider had not made the required improvements. We found two

breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

The service provided care and support to adults with a variety of needs living in their own homes. This included people living with dementia, older people, people with sensory impairments and physical disabilities. At the time of inspection there were 124 people using the service.

The service had a registered manager. A registered manager is a person who has registered with the Care

Summary of findings

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.

People told us that they did not always feel safe when staff supported them. They told us that this depended upon which staff member was supporting them.

People did not receive their medicines safely. Records did not contain important information about the medicines that people were taking and care plans did not show what support people needed with their medicines this meant that there was a risk that people might not receive the medicines they needed as prescribed by their doctor and there had been occasions when this had happened.

Risk assessments were in place which set out how to support people in a safe manner in areas such as moving and handling, nutrition and health and safety. The service had safeguarding and whistleblowing procedures in place. Staff were aware of their responsibilities in these areas.

Staff told us that they sought people's consent prior to providing their care. We saw that there were a number of consent forms in place that the service used. Where people were believed to not have the capacity to consent to their care and treatment there was no record of how the care provided had been agreed as required by the Mental Capacity Act 2005.

Care workers were supported through training to be able to meet the care needs of people they supported. They undertook an induction programme when they started work at the service.

People told us that some staff were caring and that some staff made them feel uncomfortable. Staff we spoke with had a good understanding of how to promote people's dignity.

When people started to use the service a care plan was developed that included details about their care needs and how to meet those needs. Information about people's likes dislikes and preferences were included so staff had all of the relevant information, apart from that relating to medicines, to meet people's needs.

At times care workers did not arrive on time for homecare visits. People felt that they were sometimes rushed by care workers. They told us that the care workers did not always stay for the scheduled period of time.

People told us they knew how to make a complaint. The service had a complaints procedure. The service had not recognised concerns that people raised as possible complaints.

People told us that they completed a questionnaire to provide feedback on the service. They told us that they did not get any feedback from this questionnaire.

Systems were in place for monitoring the quality of care and support provided. These had not been updated regularly and did not reflect all of the checks that had taken place.

The service had a clear management structure in place. Staff told us that they found the management approachable and felt that they were listened to.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report.

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?

The service was not always safe.

People told us that whether they felt safe depended on which staff supported from.

The service had robust recruitment procedures in place and checks were carried out on staff before they commenced working at the service.

People were not supported with their medicines appropriately.

Requires improvement



Is the service effective?

The service was not consistently effective.

Staff sought people's consent prior to providing their care. However, where people lacked capacity to consent to their care there was no record of how the care provided had been agreed as required by the Mental Capacity Act 2005.

Staff received training that was appropriate for the needs of the people they were working with.

Requires improvement



Is the service caring?

The service was not consistently caring.

People told us that some staff members were kind and friendly, and that this depended on the member of staff. They told us that some staff made them feel uncomfortable.

Staff we spoke to had a good understanding of the needs of the people they supported regularly.

Requires improvement



Is the service responsive?

The service was not always responsive.

People told us that they were sometimes provided with care and support that they needed.

People told us that staff were often late and did not stay for the time they were allocated.

A complaints procedure was in place. Concerns were not consistently recorded as complaints and investigated.

Requires improvement



Is the service well-led?

The service was not consistently well led.

People told us that things did not change after they provided feedback.

Requires improvement



Summary of findings

Systems were in place for monitoring the quality of care and support provided but these were not always implemented.

Staff felt able to approach the manager with any concerns and felt that they were listened to and valued.

Bradgate Homecare Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 19 and 20 November and we returned on 2 December 2015. All days were announced. 48 hours' notice of the inspection was given because the service is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.'

The inspection was carried out by an 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. The expert had experience of caring for someone who used this type of service.

Before our inspection, we reviewed the Provider Information Return (PIR). The PIR 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 also reviewed information we held about the service and information we had received about the service from people who contacted us. We contacted the compliance team from Leicestershire County Council to obtain their views about the care provided. The compliance team work with a provider to ensure that they are meeting their contractual obligations with the Council.

We reviewed a range of records about people's care and how the service was managed. This included eight people's plans of care and associated documents including risk assessments. We looked at four staff files including their recruitment and training records. We also looked at documentation about the service that was given to staff and people using the service and policies and procedures that the provider had in place. We spoke with the registered manager and four care workers.

We telephoned 20 people who used the service. We spoke with 14 people who used the service and two relatives of people who used the service. This was to gather their views of the service being provided.

Is the service safe?

Our findings

At our previous inspection carried out on 16 and 17 September 2014 we found that people were not protected against the risks associated with medicines. This was because the provider did not have appropriate arrangements in place for the safe administration and recording of medicines. This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2010 Management of Medicines; which following legislative changes of 1 April 2015 corresponds with Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We required the provider to make improvements and they submitted an action plan setting out what they were going to do. At this inspection we found that the provider had not made the required improvements.

Care staff administered people's medicines for them. This included removing medicines from a blister pack, placing them in a container and the giving them to people. Some people also required prompting. In these circumstances national guidelines determine that a full record must be kept of all medicines that are administered. The provider was not keeping such records as required and the records that were kept were insufficient and at times inaccurate.

The registered manager advised that they were considering implementing Medication Administration Record (MAR) charts to record the information in more detail and to provide a record of what medicines people had taken.

Risk assessments had been completed in relation to medicines. This considered areas including whether the person could open lids, blister packs, swallow tablets and understand instructions on medicine labels. The risk assessment identified actions needed. However these only included supervision, assistance or prompting with medicines as defined in the service's policy. The risk assessment did not recognise that staff were administering medicines or identity actions needed in relation to this.

Staff were completing training in medicine administration through a distance learning course and had signed up to this course in 2015. There were no competency checks in place to make sure that staff were assessed as competent

to administer medicines. The registered manager told us that they were going to introduce competency checks. This meant that staff were administering medicines without receiving the appropriate levels of training and support.

As the provider was not keeping the required records and staff were not sufficiently trained or supervised in this area there was a risk that people might not receive the medicines they needed as prescribed by their doctor and this had happened on occasions including two occasions in the four weeks prior to our inspection visit. This included one person being given incorrect medicines at the incorrect time and their falling and sustaining minor injuries as a result.

These matters constituted a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Safe Care and Treatment.

Some of the people we spoke with told us that they felt safe when receiving support from the care staff. One person told us, "I feel safe with them, and they are quite caring." Other people told us that they did not always feel safe when receiving support from the care staff. Comments included, "I haven't always felt safe with my carers" and, "It doesn't instil confidence in me that she was able to care for someone like me." People told us that their care was not always consistent and varied depending on which carer arrived. This caused concern for people. A relative told us, "It all depends on who is coming, [person's name] is a bit edgy about one of them in particular, she doesn't feel as safe with her as with others."

Care workers we spoke with had a good understanding of types of abuse and about what actions they would take if they had concerns. All the staff we spoke to told us that they would report suspected abuse immediately to the office. The provider had a safeguarding policy and the actions the staff described were consistent with the policy. Staff told us that they had received training about safeguarding adults. The training records showed that staff had received this training and this was in date. All the staff members we spoke with told us that they understood whistleblowing. The procedure in place did not make it clear that people had the right to whistle blow to outside agencies. The registered manager had an understanding of their responsibility for reporting allegations of abuse to the local authority and the Care Quality Commission (CQC).

Is the service safe?

The registered manager had reported most concerns appropriately to the local authority adult social care team and the concerns had been investigated either internally or by the local authority. They had not reported one incident that should have been reported where a person remained in their chair all night because a care worker had not made a scheduled visit. We discussed this with the registered manager who agreed that they would report this.

Staff told us that risk assessments were carried out when people started to use the service. We saw that risks relating to people's care were assessed and control measures had been put in place to ensure that risks were reduced. These included assessments about moving and handling, nutritional risk, finances and health and safety. Risk assessments were reviewed annually unless a change had occurred in the person's circumstances. The risk assessments we looked at had not all had a review in the last year. The registered manager told us that they were in the process of reviewing all files.

The registered manager told us that all accident and incident forms were checked and signed by a coordinator or the registered manager. They told us that they were developing a graph to monitor incidents and accidents and to help them identify if there were any patterns. We saw that the registered manager reviewed what had happened and recorded actions that had been taken to reduce the possibility of the incident happening again. We saw that the registered manager had taken action, for example a reminder had been sent to staff about the importance of checking medication blister packs following a medication error. This showed that the registered manager was identifying concerns and taking action to address these.

There was a recruitment and selection policy in place that was followed when the service recruited staff. We looked at the staff files of four staff members and found that all appropriate pre-employment checks had been carried out before they started work. People using the service could be confident that safe recruitment practices had been followed.

Is the service effective?

Our findings

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

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

We saw that consent was considered in policies and in the fundamental values of the organisation. For example, the service had a person centred care policy that referred to people making choices and encouraging independence. All staff we spoke with told us that they would ask a person for their consent before they helped them. One person told us, “it depends on the person, I ask what they would like today and offer choices.” Another person told us, “If someone says no, I would do something else and approach again, but I would respect the person’s wishes.” This showed that staff we spoke with understood about ‘consent’. However, staff told us that they had not received training in the MCA. We discussed this with the registered manager who told us that staff were going to be undertaking training in the MCA and that they were in the process of finding courses.

We saw that as part of a person’s initial assessment before using the service they were asked if they agreed with the contents of the care plan and signed a form to agree with this. We saw that some people had signed their care plan to say they agreed with the contents of the plan and consented to the care being provided in line with the plan. Where it was believed people did not have the capacity to consent to their care someone else had been asked to sign the plan on their behalf. The MCA allows people to sign a care plan and consent to care on behalf of someone else if the correct process has been followed. The process includes completing a capacity assessment, to determine if the person lacks capacity. If the person does lack capacity then it could be agreed that the care was in their best interests involving the person and their relatives to make this decision. If a person has agreed that they want

someone to make decisions on their behalf they can appoint a Lasting Power of Attorney (LPA). This is a legal authority and the chosen person can make decisions on the person’s behalf.

The registered manager confirmed that nine of the people who used the service had not signed their own care plan for reasons including living with dementia, and being elderly and frail. This meant that it had been assumed that these people did not have the capacity to consent to their own care due to a diagnosis. The MCA says that people must be assumed to have capacity unless there is a reason to believe otherwise. Having a diagnosis of dementia or being elderly or frail is not a reason for assuming someone does not have capacity. The registered manager confirmed that no mental capacity assessments had been completed to evidence if the person did lack capacity and could not consent to their own care and there was no LPA in place for these nine people. There was no record of how the care provided had been agreed in line with the MCA and its requirements where it was believed that someone may not have the capacity to consent to their care. This meant that the requirements of the MCA had not been met and people may not have consented to the care that they were receiving.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Need for Consent.

People told us that they thought some staff had received sufficient training to meet their needs. One person told us, “I think they are well-trained. I would recommend them, there is nothing I would like changing.” Another person said, “I don’t think they are terribly well trained. I think that they could improve.” Another person told us, “I have three very good carers, but the other three that come are rubbish.” A relative told us, “I do feel that the new staff could do with a little more training.”

When staff started working at the service they undertook induction training. This included three days classroom based training which covered a range of courses. Following this new staff shadow experienced members of staff. All staff were given a copy of the staff handbook. This included key policies and procedures and the fundamental values of the organisation. Staff signed to say they had received this handbook. This meant that staff had a copy of key policies and procedures available to them at all times. All staff we

Is the service effective?

spoke to told us that they had completed their induction. One told us, “I did shadow shifts. It’s up to us how confident we felt. Normally you do ten days shadowing but you can do more.”

Staff told us that they’d received enough training to enable them to carry out their roles. Comments included, “The training is good quality, when things change its nice to jog your memory. I got a letter to ask if I needed any other training to let the office know.”, “It is good quality training and there is some ‘hands on’ training. I feel I have had enough training.”, and, “The training is good quality, you can always ask for more.” We looked at the records relating to training. We saw that staff had received training in a number of areas to assist them in their roles and to meet the needs of the people they supported. This included training in specialist areas such as catheter care and supporting people who were living with dementia. There was a training room in the office that had a bed and a hoist available so that staff can have real experience of using the equipment people had in their homes. All staff had a care passport. This recorded information about specialist training staff had received to carry out health care tasks for the people who used the service.

Staff members told us that they had supervision meetings with their manager or a team leader. One person told us, “I often miss supervision due to my shift patterns, but my supervisor is approachable and I am listened to.” We looked at the records and saw that supervisions took place. However the frequency of these was variable. The manager

told us that they were working to ensure that these were up to date and carried out on a regular basis. The supervision policy identified that each staff member should have six supervisions per year. The registered manager told us that the aim was now for staff to have four supervisions per year and the policy would be updated to reflect this.

A person using the service told us, “They make me a sandwich at lunchtime it’s always the same thing, that’s my choice. I’m happy with what I have.” Most of the people we spoke with said that they did not receive support with food and drink. We saw from the records that where people did receive support with food, details of what had been served had been recorded in the daily notes. We also saw that a nutritional risk assessment had been completed for each person that required one. Where a risk such as someone being at risk of malnutrition had been identified it was not clear that appropriate referrals had been made to health professionals in the records. We discussed this with the registered manager who advised that they had made referrals to the GP if someone was identified as being at risk of malnutrition.

Care plans contained contact details of people’s relative’s, GP’s or other involved health professionals so that staff were able to contact them in the event of an emergency. Staff were aware of their responsibility for dealing with illness or injury, telling us they would call an ambulance or the person’s GP if required and inform the office so that this information could be passed to other staff.

Is the service caring?

Our findings

People told us that some staff acted in a caring manner towards them. One person told us, “I have one lady who comes regularly she is marvellous, caring friendly, always polite and respectful. The stand ins are not quite as understanding. They don’t rush me but they are a bit dismissive.” Another person told us, “It depends on who comes really. Three of them are wonderful. They care and will do anything for me. The rest – They are so busy it seems they don’t really care.” A person we spoke with told us, “I have the same girl during the week who is fine and treats me well.” Another person told us, “They’re not the most caring people I’ve come across. I’d like the good ones to come all the time.”

Staff told us that they went on regular calls generally and this made it easier to get to know the people who used the service. One staff member told us, “If you know a client, you just know what they like and when something is wrong.” Another staff member told us, “I go to the same people all the time. I can find out what the person likes and dislikes by talking to them and their family.” This showed that staff felt that they could develop relationships with people who used the service when they saw the same people on a regular basis.

The registered manager told us that when they received an enquiry about the service they or a co-ordinator would go and visit the person and their relatives. This was to determine if the service was able to meet their needs. They said care plans and risk assessments were developed based upon information provided by the relevant local authority and the assessment of the person’s needs. This involved discussions and input from the person and their family where appropriate. This meant that people were involved in planning the care and support that they received.

People using the service told us that the staff who had been with the service for ‘some time’ knew their likes and dislikes, but that not all staff knew this information. One person told us, “I’m very sensitive. Some of them don’t listen to how I want things done.” A relative told us, “I think the new staff could do with more information about the person, their condition and background information. Some of them listen to [person using service], but some don’t.” Staff members we spoke with knew people they supported regularly well and were able to tell us about their likes and dislikes. They told us that when they visited people on a regular basis it helped them get to know the person and how best to support them. We saw that information about people likes and dislikes, what is important to the person and the best way to support the person were recorded within their person centred care plans. This meant that care workers had all of the relevant information about the things that were important to people and how people wanted their care and support provided.

One person told us that they felt uncomfortable with some staff when receiving personal care. They told us, “I think they take on too many young girls, they are uncomfortable giving person care and so am I.” Another person told us that a member of staff made her feel uncomfortable, “She gossips and tells me about other people. I have told her not to do this.” Staff told us how they promoted people’s dignity, including talking to the person throughout and explaining what they were doing, prompting people to do things for themselves, and asking people what they want to do and involving them in their care. One staff member said, “I like to chat to people when giving personal care. It makes people more comfortable.”

We saw the results from a quality assurance audit carried out in April 2015. This showed that all 58 respondents felt that the staff member’s attitude was excellent, very good, or good. All respondents felt that staff were respectful to them.

Is the service responsive?

Our findings

People told us that the service was sometimes responsive to their needs and that some staff had a good understanding of how to support them. One person told us, “They are efficient at changing visit times for particular reasons. They are very reliable I appreciate that.” Another person told us, “I would like to go to bed at 9:30pm or even later, but they turn up about 8 – 8:45pm and say you are my last one, I have got to go home. I now have to take sleeping tablets or I would not be able to stay in bed until they come in the morning. It is very frustrating”. One person we spoke with told us, “My carer goes above and beyond what is expected. If I have a shower they do it the way I like it.” A relative told us, “At the weekend her hearing aid is rarely put in by the carer. Some of them say they don’t know how to do it.” Another relative told us, “when the regular carers come things work well but when the staff are not the usual staff there can be problems. “[Person’s name] chooses not to have a shower on these days because she feels they do not understand her needs, she gets herself dressed and ready even though she has bad arthritis as she finds it less stressful.”

We found care plans were in place for people. Copies of care plans were held at the service’s office and also at people’s home. The meant that people who used the service and their care staff were able to consult the care plan. Care plans included information about what people needed support with. Care plans included two sections? One listed tasks that the staff needed to complete. The second was a person centred care plan and included information about how the person wanted their support providing. For example, the care plan for one person highlighted that as part of their morning routine the person liked a shower in the morning and then liked a cup of tea, with one sugar. Staff had a good understanding of the care and support needs of the people they worked with regularly. Staff told us that they could look at the care plan for the information. When supporting a new person staff felt that the information they received was not detailed. One staff member told us, “It is not nice for the people if you go to someone and they don’t know you. It would be helpful to have a phone call to let us know information about the person before we went.”

The registered manager told us that care plans were reviewed every six months or more frequently if required.

We looked at records that contained information about reviews that had taken place and found that 20 reviews had not taken place. The registered manager confirmed that a number of these reviews had taken place the previous day via telephone with people who used the service and the records needed to be updated to reflect this.

People told us that they did not always know which staff would be coming. One person told us “I may have a rota, but it’s not often accurate. I know somebody’s coming but I can’t trust who is coming.” Another person told us, “It’s not always very accurate – I have not had one for some weeks.” Staff told us that people received a rota if they requested one. We saw records that monitored the planned call time against the actual call time. On most occasions staff were within ten minutes of the planned call time but the variations made it difficult for people using the service to know when staff would arrive.

People told us that the staff were often late, and that although they apologised when they arrived they did not call people to let them know they would be late. One person said, “Punctuality is the problem for me. I’d like them to come between 9:30 and 10am but it can be as late as 11:30am, my problem is I’m awake very early and it’s a long wait. They don’t ring up, but when they do turn up they apologise.” Another person told us, “I don’t get a phone call – I usually ring them. It would really help if they rang me, it would reassure me someone was on the way.” The staff told us that they visited people on a regular basis and that they were generally on time when they were working with their usual list of home calls. The registered manager told us that they had a new system to monitor the calls and make sure that people were arriving on time. They told us that the system was active from the first day of the inspection and this would alert staff in the office if staff were more than 30 minutes late for a time critical call. This type of call is when someone requires support at a specific time, for example a medicine that needs to be taken at a certain time. The registered manager told us that the system would also raise an alert if staff were more than one hour late for non-time critical calls.

People told us that they sometimes felt rushed by the staff. One person told us, “There was one occasion when I felt extremely rushed by one of them. Staff don’t seem to understand that I cannot move quickly.” A relative told us, “She [carers name], used to rush her and talk to her the whole time she was eating, and when I went in afterwards

Is the service responsive?

[persons name] would be burping because of being rushed. Twice she was sick as a result.” The relative confirmed that this person no longer had support with their meals at lunch time and is much better as a result of that.

People told us that not all staff stayed for the time they were allocated. One person told us, “She should have stayed for 45 minutes but left in eight.” Another person told us, “She was here for five minutes, but put 30 minutes in the book.” A relative told us, “The staff are meant to ring the office to make sure that they stay for the right time. Some people will ring and say they have arrived, and not ring to say they are leaving, or vice versa. They will write down the times they should have been here.” We looked at records of monitoring the length of call times. We saw that there were times when staff did not confirm the time of arrival and the time of leaving. The registered manager told us that this was monitored and discussed with staff if it seemed that this was happening frequently.

People told us they knew how to make a complaint. A relative told us, “I’ve never made an official complaint, but I did phone up once about some concerns I had. They sounded concerned but I have not seen any difference.” Another relative told us, “I rang them up about someone [persons name] was not happy with. They wanted to try mediation but [person’s name] did not want them back. I’m pleased to say she hasn’t come again.”

The service had a complaints procedure in place. This included timescales for responding to any complaints. The registered manager told us that all people were provided with a service user guide that contained a copy of the

complaints procedure, and we saw that this was included within the service user guide. We saw from the quality questionnaire that the service asked people if they were aware of the complaints process. 36 respondents said that they were aware of the procedure. 15 respondents said they were not. 5 respondents were not sure. The registered manager told us that following this people who said they did not know about the procedure or were not sure were contacted and reminded of where to find the procedure. This meant that people were being told that there was a procedure in place in case they wanted to make a complaint. Staff told us that if they received a complaint from a person they would report it to the office.

The registered manager told us that they had received two complaints. We saw from the records that they had been recorded and investigated. The outcomes of the complaint had been communicated to the person who made the complaint. We saw that one person had written a letter to the service saying they did not want a specific member of staff, and had discussed this three times with the service. The registered manager advised that they had contacted the person who said they did not want to complain. The member of staff did not go back to the person. A relative told us, “I have reported one staff member, it made no difference. I rang the office and insisted on speaking with the manager. She booked to visit me. This appointment was cancelled and has not been rearranged. I don’t feel listened to at all.” This meant that people’s concerns were not being recognised as complaints and investigated appropriately.

Is the service well-led?

Our findings

People told us that they had received questionnaires from the service. One person told us, “We get a questionnaire at least once a year.” Another person told us, “I always tell them what I think. There have not been any results though. Nothing changes.” People told us that they knew who the manager of the service was. One person said “I spoke to the manager once, but nothing has really changed.” A relative told us, “If I need to ring I will always ask for a co-ordinator because she will always ring me back. She is very good. Otherwise you never get a call back.”

The service had quality assurance and monitoring systems in place, including a questionnaire that was sent to people who used the service twice a year. This asked people for their feedback on staff, the service and how well they thought the service was doing. People were asked for their views on areas such as the attitude of staff, their reliability and helpfulness, people’s experience of contacting the office and the complaints process. There was also a section of the questionnaire where people could provide feedback on other areas of the service. We saw the results from the survey sent in April 2015. There were 58 responses received. The registered manager told us that she looks at the results from this and either they or the quality supervisor will contact people to discuss any concerns with them on a one to one basis and try to resolve these with them.

Co-ordinators were carrying out spot checks at people’s homes while staff was providing support. These checks were to monitor staff behaviour and attitude to check that they displayed the provider’s values of treating people with dignity and respect. We saw that not all staff had received a spot check. The plan was that these would take place as often as possible and at least every six months. The registered manager advised that checks were being carried out. One staff member told us, “I had a spot check about six weeks ago.”

We saw that there were records in place to monitor staff supervisions, care plan reviews for people using the service, training, checks on equipment that was used in people’s homes and recruitment checks. Information in the monitoring records had not been updated recently. This meant that it was not possible to evidence if monitoring had taken place. The registered manager told us that checks and reviews had been carried out and the paperwork would be updated to reflect this.

We saw that care plan reviews were carried out with people and this could be in the form of telephone interviews. The registered manager told us that a number of care plan reviews had been completed the day before the inspection. This was to see if people were happy with the service and their support or if they had any concerns. We saw records of care plan reviews that had been carried out previously.

We looked at daily records for people who used the service. The last records in the office for one person were from February 2015, for two other people the last records were from July 2015 and September 2015. The registered manager advised that the daily notes should be brought back to the office six weekly and that these would then be audited. This meant that daily notes which were a source of contemporary evidence about the delivery of care were not reviewed for several months. There was a risk that evidence of concern would not be addressed promptly. The registered manager advised that they would remind the staff to return all records so that these can be checked.

Staff members told us that they could approach the manager or the co-ordinators at any time. They told us that they felt that they were listened to and changes would be made if they were needed. One care worker told us, “I have seen changes made when staff provided feedback. The rota was changed after staff said that it was not working.” Another care worker told us, “I was asked to do an extra shift and I said no. The company listens to us.” All the staff we spoke with told us that they speak to their manager regularly and were encouraged to make suggestions at staff meetings. Records of staff meetings showed that there had been discussions about what could be improved with the service delivery. The staff told us they felt confident to discuss the service at any time.

We saw that a recent staff meeting had taken place in September where staff were able to raise any issues and concerns. We also saw that a specific meeting had been arranged to discuss an area of concern from an incident that had taken place. The minutes were available for staff to read if they had been unable to attend.

All staff we spoke with told us that they felt valued. One told us, “I really enjoy it here, they have respect for us.” All staff we spoke with could tell us what the organisations values were. These were available in the staff handbook and

Is the service well-led?

service user guide so that staff and people who used the service were aware of the values. Staff told us that there was an employee of the month scheme and rewards each month.

We spoke with Leicestershire County Council who contract with the provider. Feedback received was that the service was compliant with contract.

The service had a registered manager in place and there was a clear management structure. The registered manager was supported by a quality supervisor, co-ordinators and office staff. They told us that they felt supported by the staff.

The registered manager told us that they understood their responsibilities to report incidents, accidents and other occurrences to CQC. However, we had not received any reports of incidents. We saw from records that there were two incidents that should have been reported to the local authority and to CQC. The registered manager agreed that they would make sure these were reported.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>How the regulation was not being met: Records did not evidence what medicines people were receiving. Care plans did not record what support people required to take their medicines. Regulation 12 (2) (g).</p>

Regulated activity	Regulation
Personal care	<p>Regulation 11 HSCA (RA) Regulations 2014 Need for consent</p> <p>How the regulation was not being met: Decision specific mental capacity assessments had not been carried out where there were concerns identified about people's capacity to consent. Where a person was unable to give consent to a specific decision the service had failed to act in accordance with the MCA. Regulation 11 (3).</p>