Perfect Care Limited

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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

The inspection took place on 21 and 22 March 2016 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

We last inspected Perfect Care on 11 February 2014, at which time it was meeting all our regulatory standards.

Perfect Care is a domiciliary care provider based in Spennymoor providing personal care to people in their own homes in the County Durham and Darlington area. The service is also registered to provide nursing care in people's own homes although no one was receiving nursing care at the time of our inspection. At the time of our inspection the service provided personal care to 112 people.

The service had a registered manager in place. A registered manager is a person who has registered with the CQC 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. The registered manager had extensive experience of working in the social care sector.

We found the service had in place a range of risk assessments to ensure people were protected against a range of risks and that these risk assessments were regularly reviewed.

There were effective pre-employment checks of staff in place and effective supervision and appraisal processes, with all staff we spoke with confirming they were well supported.

Medicines administration was found to be safe and in line with recognised good practice, with people not at risk of unsafe medicines administration.

We found infection control procedures were in place and people were protected against the risk of acquired infections.

People who used the service, relatives and external healthcare professionals expressed confidence in the ability of staff to ensure people were safe. No concerns were raised from relatives, external healthcare professionals or local authority commissioning professionals on this issue.

We found there were adequate staff to ensure people's needs were met safely. We found policies regarding the planning of care calls were clear but, on occasion, the staffing rota had not been managed to ensure the adequate provision of travel time.

We found staff were trained in core areas such as safeguarding, food hygiene, first aid, as well as training specific to the individual needs of people using the service, for example dementia and PEG feed training.

We found staff had a good knowledge of people's likes, dislikes, preferences and communicative needs.

We found care plans to be person-centred and sufficiently detailed so as to give members of staff a range of relevant information when providing care to people who used the service. We saw these care plans were reviewed regularly and with the involvement of people who used the service, relatives, healthcare professionals and, where applicable, advocates. We saw professional advice was incorporated into care planning and delivery.

The registered manager displayed a good understanding of capacity and the need for consent throughout care practices. We saw one person had been supported to receive the support of an advocate.

People's changing needs were identified and met through liaison with a range of external health and social care professionals and we saw these interactions were clearly documented.

We saw the majority of complaints were comprehensively responded to, with one not being responded to by the registered manager – they undertook to rectify this. People we spoke with and relatives told us they knew how to make a complaint if they needed to, and to whom.

Staff, people who used the service, relatives and other professionals praised the support they received from the registered manager and we found the registered manager and nominated individual to have a good corporate oversight of the organisation, as well as a knowledge of people who used the service.

We saw the registered manager had in place a range of audits to identify areas of concerning practice. We saw where discrepancies had been identified these had been addressed and communicated to staff.

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.

All people who used the service, relatives and professionals we spoke with expressed confidence in the ability of the service to keep people safe.

Risk assessments were detailed, individualised and regularly reviewed to manage and mitigate risks people faced. Where concerns were identified we saw relevant agencies were involved to keep people safe.

Pre-employment checks of staff ensured the service reduced the risk of unsuitable people working with vulnerable adults.

Is the service effective?

Good

The service was effective.

People received a range of positive outcomes to their health through the ongoing involvement of a range of healthcare professionals.

Staff received a range of mandatory training as well as training specific to the needs of people who used the service, such as dementia awareness training.

Policies regarding the planning of care calls were clear but, on occasion, the staffing rota had not been managed to ensure the adequate provision of travel time.

Is the service caring?

Good

The service was caring.

People, relatives and professionals spoke consistently of the compassionate approach by staff. Numerous people we spoke with were happy to share their experiences of positive interactions with staff.

People were treated with dignity and respect, in line with the standards set out by the service in the company literature.

People were involved in the planning of their own care, with people's voice apparent in the details of care plans.

Is the service responsive?

Good

The service was responsive.

Care plans were subject to regular review, with people and their relatives involved.

Where people's needs changed staff liaised with external care professionals to ensure people's needs were met, incorporating advice into care planning.

People who used the service and others knew how to make a complaint and who to. One complaint was not comprehensively dealt with but others were, in line with the service's policy.

Is the service well-led?

Good

The service was well-led.

The majority of people and relatives we spoke with were extremely positive about the approachability and knowledge of the registered manager.

Auditing of service provision was sound, with discrepancies identified and corrective actions undertaken.

Good practice and reminders to staff were shared via staff supervisions, appraisals and a regular 'team brief' communication.

Perfect Care 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.

We visited the service on 21 and 22 March 2016 and our inspection was announced. The members of the inspection team consisted of one adult social care inspector and one expert by experience. An expert-by-experience is a person who had personal experience of using or caring for someone who used this type of care service. The expert in this case had experience in caring for older people and people living with dementia.

On the day we visited we spoke with the registered manager, the nominated individual (who was a director of the service), the deputy manager and three members of care staff. Following the inspection we spoke with eight people who used the service and three relatives. We also spoke with one local safeguarding professional.
During the inspection visit we looked at people's care plans, risk assessments, staff training and recruitment files, a selection of the service's policies and procedures, meeting minutes and maintenance records.

Before our inspection we reviewed all the information we held about the service, including previous inspection reports. We also examined notifications received by the Care Quality Commission. We contacted the local authority commissioning team and Healthwatch, who raised no concerns about the standard of care provided. Healthwatch are a consumer group who champion the rights of people using healthcare services.

Before the inspection asked the provider to complete a Provider Information Return (PIR). This document sets out what the service feels it does well, the challenges it faces and any improvements they plan to make. We used this document to inform our inspection. We also reviewed responses to questionnaires CQC sent to people who used the service (31.4% responded), relatives (8.5%), staff (5.7%) and community professionals (25%). We used these results to inform our inspection.

Good

Is the service safe?

Our findings

People who used the service and their relatives consistently told us they felt safely cared for by staff and that they had no concerns regarding their safety. One person told us, "They help me with personal things, washing, showering, I am much safer with their help". Relatives told us, "We both feel safe with them, we know they are looking after us," and, "The care staff are very good, my [Person] feels safe and confident with them, with their help they can manage to take a shower regularly and they know they will support him, [Person] has no worries about falling." When we spoke with an external healthcare professional they raised no concerns about the ability of staff to keep people safe. Questionnaires returned from people who used the service, staff, relatives and community professionals showed all respondents agreed or strongly agreed that people were, "safe from abuse or harm".

Risk assessments were undertaken at a primary assessment stage (looking at, for example, immediate environmental and mobility risks), then a full risk assessment when the person started using the service, which was subject to regular reviews. When we looked at risk assessments and associated care plans we saw there were detailed instructions to help staff perform people's care safely. For example, where someone required the use of a hoist when bathing, we saw instructions regarding how many staff were required and about their respective roles, were clearly written. We also saw these plans were detailed in terms of how much capacity the person receiving care had and how they liked to be involved in the delivery of their care. This meant risk assessments did not forget to treat people as individuals, whilst also minimising risks to their safety.

Where there had been safeguarding concerns about a person using the service in the past, we saw staff took prompt action to ensure the person was kept safe from the risk of financial abuse and relevant professionals such as police and Social Care Direct were informed from the outset. Social Care Direct is a dedicated telephone line providing advice and support to people who require help to live independently. This demonstrated staff were able to put safeguarding principles into practice to ensure people were protected from the risks they faced.

Questionnaires returned to CQC from staff members stated they were confident in how to report concerns of abuse and who to report them to. When we spoke with staff during the inspection they were able to tell us what constituted abuse and how they would go about raising any concerns. They were able to tell us they would be mindful of changes in people's behaviour, or unexplained bruises, for example. We found their responses to be in line with the service's safeguarding policy. We saw safeguarding information such as relevant contact information for the local authority safeguarding team, was prominently displayed in the staff room area. Other information pertaining to keeping people and staff safe was readily available to staff and included the lone worker policy, whistleblowing information and the staff code of conduct.

We reviewed a range of staff records and saw that all staff underwent pre-employment checks including enhanced Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they are considered to present a risk and also provide employers with criminal history information. At staff supervision meetings the registered manager asked staff to confirm that they

had not been convicted of any offences since their last DBS check. We also saw that the registered manager asked for at least two references and ensured proof of identity was provided by prospective employees prior to employment. Where a referee had not responded to a request for a reference we saw the registered manager had pursued this to assure themselves about the suitability of prospective staff. This meant that the service had in place a robust approach to vetting prospective members of staff and had reduced the risk of an unsuitable person being employed to work with vulnerable people.

The service had adequate medicines policies and procedures in place. We reviewed the medicines policy and found it to be informed by guidance from the Royal Pharmaceutical Society (RPS), the National Institute of Health and Care Excellence (NICE) and the Social Care Institute for Excellence (SCIE). The policy provided clear instruction on the provider's administration of medicines. We saw that appropriate medicine administration training had been delivered and that the annual supervision of staff was in place to assure their competency with medicines administration. When we spoke with staff they were able to discuss the medicines procedures they adhered to in line with the medication policy and people's assessed needs, giving details about specific impacts of medicines and their side effects. We saw medicines audits were effective, ensuring medicines records were in line with good practice and corrective actions taken where any discrepancies were identified, for example on a Medication Administration Record (MAR) not being appropriately signed. This meant that people were protected against the risk of the unsafe administration of medicines.

We saw that any accidents and incidents were recorded and reviewed on a monthly basis by the registered manager to try and identify any common trends or patterns. We saw these instances were infrequent and no trends or patterns were evident that had not been identified.

With regard to infection control we saw staff had been trained appropriately and, when we spoke with people who used the service, they confirmed staff used personal protective equipment (PPE) such as gloves when performing personal care. One person said, "Their hygiene is very good," whilst another told us, "They always clear up after themselves." We saw staff had undergone training regarding the Control of Substances Hazardous to Health (COSHH) and risk assessment training, meaning they were given additional training on the hazards they and people they cared for might face before going into people's homes.

We saw there was an 'out of hours' contact number for staff, should they have any concerns outside of office hours. Staff we spoke with confirmed they always had support if they needed to raise concerns and we saw that all staff who had completed induction documentation had signed to confirm they knew how to seek help out of hours.

All staff we spoke to felt staffing levels were sufficient to keep people safe.

Good

Is the service effective?

Our findings

When asked whether care workers arrived on time, two out of ten people who used the service who returned questionnaires to CQC either disagreed or strongly disagreed with this statement. The rest agreed that care workers arrived on time. Two relatives responded to this question, with one relative disagreeing with the statement. When we spoke with people who used the service, three of them told us staff were regularly late, although the other five people had no concerns in this regard. One person said, "They are timetabled to leave one person at 8pm and their next call is 8pm, there is no travel time, so they are often late." Two other people we spoke with told us, "They are normally on time, or within a few minutes," and, "If they are going to be late someone normally rings us to let us know." Opinion was divided on the timeliness of care calls, according to the people we spoke with, although the majority of people confirmed staff arrived in a timely fashion. People confirmed no calls had ever been missed.

We looked in more detail at a sample of staff rotas and found instances where care visits had not been planned in line with company policy or best practice. The National Institute for Health and Clinical Excellence (NICE) guidance, 'Home care: delivering personal care and practical support to older people living in their own homes (September 2015)' states providers should, "Ensure service contracts allow home care workers enough time to provide a good quality service, including having enough time to talk to the person and their carer, and to have sufficient travel time between appointments." We found on occasion this had not happened. For example, for one staff member we saw one care call ended at 4:55pm in one village, yet the next care call started at 4:55pm in another village. We saw another staff member was due to finish one call at 5pm and start another call at 5pm. Such instances accounted for 15% of the care calls we sampled.

In one communication to all staff we saw the registered manager had written, "Staff are still not recording the actual times that they arrive and leave," indicating that this had been a problem since at least January 2016. We spoke with one member of staff who confirmed they had calls allocated as starting at the same time another call ended. They stated this made them anxious and meant some people receiving care did not always receive care at the time that had been agreed. They told us, "There isn't enough time to cover all the calls and it can have an impact on people." All other members of staff we spoke with felt the scheduling of care calls was manageable and appropriate.

When we spoke with the registered manager and nominated individual about this issue they acknowledged there had been difficulties organising the rota previously and that the practice of starting one call at the same time another ended was not common practice. We saw the relevant policy and previous instructions to staff made it clear that care co-ordinators should include appropriate travel time when scheduling the rota. We also saw the service had in place an electronic monitoring system, which meant care staff 'logged in' when they arrived at a person's house and 'logged out' when they left. This meant the registered provider was able to monitor whether any calls had been missed. We found no evidence of calls being missed and that people who used the service were sent a weekly printout of which carers to expect and when for the week ahead. The registered manager and nominated individual undertook to address the recurrence of the staff rota problem immediately.

With regard to the effectiveness of care otherwise, people who used the service and their relatives were clear, particularly with regard to the effectiveness of individual members of care staff. 93% of respondents to CQC questionnaires stated they would recommend the service to others, whilst all respondents confirmed that staff completed all of their tasks at each visit and supported people to be independent. People we spoke with told us, "I was never used to having care, but I don't know what I would do without them now," and, "Two carers come together, they help me get in and out of bed, shower and dress, they are very good at their jobs." One thank-you card to the service stated, "Please thank [Carer's name] for all their great care and support at a difficult time. They do a wonderful job." People confirmed that, where two carers were scheduled to support them, they always arrived as a pair.

We found staff had the knowledge and skills to meet people's needs. Training the registered provider considered mandatory included safeguarding, dignity and respect, equality and diversity, first aid, health and safety, food handling/hygiene, infection control, mental capacity and end of life care. We saw staff were also trained in subjects specific to the individual needs of people who used the service, for example dementia awareness training and percutaneous endoscopic gastrostomy (PEG) feeding training. A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. This demonstrated the registered provider put in place training to ensure staff had the relevant skills to meet people's individual needs.

The registered manager also told us they were in the process of recruiting a training and development manager to ensure the professional competence of staff was monitored as the service grew. We saw the service had a staff room that was adequately equipped to deliver training, with a bed and model to help deliver moving and handling training. The registered manager was a qualified trainer and delivered this training face to face.

Staff told us they were well supported by their manager. One told us, "The training is good and they supported me when I had to take some time off." Likewise, all four staff respondents to the CQC questionnaire stated they were well supported to meet people's care needs with regard to training and professional support. They also confirmed they had completed the induction process as per the registered provider's policy and we spoke to other staff who confirmed this to be the case. We also saw the registered manager had recently introduced an induction 'exit' questionnaire, whereby staff who had just completed the induction were asked for their feedback regarding the process. We saw these responses had been compiled and the registered manager told us they reviewed these responses to see if the induction process could be improved.

We saw the registered manager sought evidence of new staff member's previous training experience where they had previously worked in the care sector. We saw staff appraisals took place annually, whilst staff supervisions took place regularly. Staff supervision meetings take place between a member of staff and their manager to review progress, address any concerns and look at future training needs. We also saw the registered manager had helped one member of staff to complete their NVQ Level 2 in Health and Social Care and had helped the member of staff work through concerns they had about their own writing abilities with the use of a Dictaphone and informal coaching.

Staff told us, "We get fantastic support and training is always updated," and, "We can approach them with anything." Likewise we saw a range of responses in recent staff surveys indicating that all respondents felt supported by their line manager. Comments included, "If I have concerns management are very willing to listen and act." This meant that staff received a combination of formal appraisal, supervision and other support as and when required to fulfil their roles.

We saw that staff meetings did not happen but the registered manager kept all staff appraised of changes to working practices through all-staff emails, individual meetings where necessary and a monthly communication called the 'team brief', which thanked staff for their efforts, for example during periods of adverse weather, and highlighted any areas of practice they needed to be aware of. Staff we spoke with stated this level of support was adequate for their needs and went on to state, "There is always a care co-ordinator at the end of the line," and, "They're really supportive."

We saw evidence of prompt and effective communication with other healthcare professionals to ensure people's healthcare needs were met, such as GPs, chiropody practitioners, specialists, dentists and opticians. This meant the service recognised people's needs and took action to meet 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.

We saw that members of staff had been trained on the subject of Mental Capacity recently and were comfortable talking about the subject. The registered manager demonstrated a good understanding of mental capacity considerations, presuming capacity and identifying the need to ensure people were given support to make decisions where they were unable.

Good

Is the service caring?

Our findings

People we spoke with consistently praised the attitude of care staff, stating, "They do everything I ask and more." Another person said, "They are all very good - they are so helpful and cheerful," and, "They are all very caring and compassionate – I really don't know what I'd do without them now". Relatives were spoke with were similarly positive about the caring attitudes of staff.

One person confirmed their relative had developed positive, trusting relationships with their carers, stating, "I have been very surprised at how well [Person] has taken to the carers, [Person] is completely comfortable with them, [Person] enjoys their visits and he is much happier." We found further evidence of staff taking the time to build a rapport with the people they cared for, with another relative telling us, "They make time to talk to my [Person], and they have really got to know and understand them, [Person] enjoys their visits". This meant people who used the service were consistently supported by staff who knew them well.

Questionnaires returned to CQC from people who used the service demonstrated that all respondents either agreed or strongly agreed with the statements, "I am always introduced to my care and support workers before they provide care," "I am happy with the care and support I receive" and, "My care and support workers are caring and kind." These results, alongside our conversations with people who used the service, demonstrated the registered provider had ensured people's needs were met by staff who behaved kindly and compassionately when supporting people.

Responses in these questionnaires from relatives and a community professional indicated people were treated with dignity and respect. The service's employee handbook made it clear to staff that people's right to choice and dignity was paramount and we found evidence this was upheld through staff behaviours. When we spoke with people who used the service and their relatives they told us this was the case. For example, one relative said, "I was very worried about having to get care for my [Person]. They are a very private person". They went on to tell us how carers provided personal care discreetly and privately, ensuring the person who used the service was comfortable and not anxious in any way. We saw information regarding dignity champions was displayed in the staff room. The registered manager confirmed the service did not have a dignity champion in place as yet but this was something they were planning.

Whilst some people raised concerns about the scheduling of care calls, they had no reservations about the standard of care provided and confirmed they knew which carers would be arriving in advance. They also confirmed they got to know their carers and the service did not, "Chop and change" staff. One person told us, "They are kind and caring and compassionate, they always know when I am unwell". One member of staff we spoke with told us, "They always make sure you're introduced to people first." This demonstrated the service had regard to the importance of providing a continuity of care for people, which both reduced the anxieties of people who used the service and meant staff were more likely to develop a better knowledge of and rapport with the person they cared for. When we spoke with the registered manager they stated, "Continuity is important for the people we care for – we try to make sure people know who is going to care for them." The importance of maintaining a continuity of care was highlighted as an area of best practice for domiciliary care providers in guidance issued by the National Institute for Health and Clinical Excellence

(NICE) in their publication, 'Home care: delivering personal care and practical support to older people living in their own homes' (September 2015).

When we reviewed care plans we saw people had played an active role in the planning of their care, with instructions to staff written in the person's voice and with an attention to detail that meant care plans were person-centred.

We reviewed compliments received by the service, which provided further evidence of the caring approach of staff. Comments included, "I am so grateful for your kindness and patience during this difficult time," and, "I would like to thank you for the service your staff have given [Person]. They have been a credit to your company and to the training they have received, they have all been excellent."

When we spoke with staff we found they had a good knowledge of people they cared for, both in terms of medical needs and personal interests, likes and dislikes. Staff we spoke with were passionate about the care they provided to people who used the service and took pride in the difference they made in people's lives.

We found the registered manager had a good understanding of how to support people through an advocate where they were unable to make certain decisions themselves. We saw one person had recently been appointed an Independent Mental Capacity Advocate (IMCA) and the registered manager had worked with external social care professionals and family members to ensure the persons best interests would be considered.

We saw people's sensitive personal information was securely held in locked cabinets and password protected computer systems, whilst staff underwent confidentiality training. We found there to be a clear and current data protection policy in place.

Good

Is the service responsive?

Our findings

People we spoke with were positive about the ability of individual staff members and the service as a whole to respond to their changing healthcare needs. We saw evidence in care plans of the registered manager liaising with external healthcare professionals to ensure people's needs were met. The service regularly assessed a range of input to ensure people's care plans were accurate and responsive to the changing needs of people. For example, we saw advice had been sought from the Speech and Language Therapy Team (SALT) regarding one person's dietary needs. They had recently been given a percutaneous endoscopic gastrostomy (PEG). A PEG is a tube passed into a patient's stomach through the abdominal wall as a means of feeding when oral intake is not possible or adequate. We saw the person had enjoyed foods such as ice cream and yogurts previously. We saw the registered manager liaised with the SALT team to ensure the person could still taste these flavours by way of 'tasters'. This is a method of giving a person a taste of a smooth food in extremely small amounts so they can enjoy the sensation of tasting (whilst having their nutritional needs met via the PEG). We saw the advice from SALT had been clearly incorporated into the person's care plan.

We found care plans generally to be comprehensive and easy to follow, with the latest care plan following the latest review available in hard copy in people's homes and electronically in the office. Where contact had been made with external healthcare professionals we saw this was documented in well-ordered files in the office. We saw care plans were person centred and contained a good amount of information that gave staff details that would assist them, such as the person's preferred first name, their religious belief and their interests. Each aspect of care set out in the care plans was accompanied by what outcome the person who used the service wanted, for example, "I want to be reassured by staff, particularly when I'm in the hoist."

We saw evidence of people, their relatives and advocates involved in regular reviews of their care plan, as well as being consulted when needs arose. All people we spoke with and their relatives confirmed they were invited to take part in these reviews. We reviewed questionnaire responses returned to CQC by people who used the service and saw all 11 respondents strongly agreed with the statement, "I am involved in decision-making about my care and support needs." All 11 respondents also either agreed or strongly agreed with the statement, "If I want them to, the care agency will involve the people I choose in important decisions." This demonstrated the registered provider ensured care was provided with the preferences of people who used the service in mind. The service also assessed a range of input to ensure people's care plans were accurate and responsive to the changing needs of people.

Each person who used the service had a key worker and when we spoke with staff they displayed a good knowledge of people's needs, likes and dislikes.

We saw the majority of calls the service provided were to help with personal care or complete household tasks. Within this context we found evidence that people who used the service were encouraged to develop and maintain levels of independence. For instance, one person told us, "They have encouraged me to keep my independence, they help me to do things for myself" and gave examples of household tasks they completed, with help when needed. One relative told us, "Since [Person's] time with the care staff, they

have improved enough that we have been able to reduce the amount of care [Person] needs." This demonstrated people were effectively supported to maintain independence at their pace.

One healthcare professional we spoke with raised concerns about the possibility of staff not completing day-to-day tasks and using the pretence of improving people's independence to do so. Through our conversations with people who used the service and their relatives we did not find evidence of this in practice.

One person who used the service who responded to the CQC questionnaire disagreed with the statement, "My care and support workers respond well to any complaints of concerns I raise." We reviewed the registered manager and nominated individual's response to a range of complaints. They had received 8 complaints in the past year. We saw, whilst there was no complaint audit in place, these complaints had been analysed to establish any trends or patterns. We saw a pattern had been identified regarding complaints about the management of the times of care visits. We saw the registered manager had taken action to address this with a change of personnel managing the rota. At the time of inspection however we found this change had not stopped instances of poor rota management, as discussed in the Effective key question. The registered manager acknowledged they needed to do more to ensure the root problem behind the complaints was resolved.

We saw one recent complaint had not been appropriately responded to. The complainant had written a lengthy letter to the registered manager who had documented a record of telephone correspondence with the complainant but had not formally responded to their written concerns. The registered manager and nominated individual acknowledged this and stated they would rectify this by formally responding to the individual.

We found this failure to respond to one person's concerns to be an isolated instance. We saw other instances where complaints had been thoroughly investigated and responded to, to the satisfaction of people who used the service and their relatives. The majority of people we spoke with, and their relatives, were confident they could raise concerns with members of care staff and management. Similarly, one external healthcare professional we spoke with stated the registered manager had always acted responsively to any concerns or queries raised by them.

We saw the service routinely gathered people's opinions about their care through a range of means. This included an annual survey, as well as more regular reviews of people's care plans, involving their relatives.

Good

Is the service well-led?

Our findings

People who used the service confirmed they knew who the registered manager was and that they retained a level of interaction with them. One person said, "The manager often calls out to see me," and another, "The manager often calls out to see if everything is all right." Two external healthcare professionals stated they felt the service was, "Well managed."

At the time of our inspection, the service had a registered manager in place. A registered manager is a person who has registered with the CQC to manage the service. The registered manager had extensive experience of working in adult social care and displayed a good knowledge of people who used the service and the systems and processes of the organisation.

All four staff who responded to the CQC questionnaire agreed with the statement, "My managers are accessible and approachable and deal effectively with any concerns I have." Similarly all people who used the service who responded to questionnaires confirmed they knew who to contact at the care agency if they had queries and that information they received from the agency was, "Clear and easy to understand."

We found staff morale to be positive when we spoke with them and in the questionnaires returned to CQC by staff members, all four respondents strongly agreed with the statements, "I would feel confident about reporting any concerns or poor practice to my manager," "My managers ask what I think about the service and take my views into account," and, "The staff in the office give me important information as soon as I need it." This latter comment was not shared by all staff we spoke with, one of whom raised concerns about the effectiveness of office staff to co-ordinate care calls. We found these concerns to be justified and these concerns are discussed in more detail in the Effectiveness key question. With specific regard to the level of leadership and support from the registered manager, all staff we spoke with were positive.

We generally found a consistency between the policies and procedures the service maintained and the practices in place, as evidenced through discussions with people who used the service and care documentation. For example, the registered manager stated one way they ensured staff felt respected was to ensure compliments received were shared and celebrated. We saw one staff personnel file had a recent compliment from a person who used the service copied and made part of the staff member's care file. The registered manager also showed us how they had introduced an employee of the month scheme to celebrate good practice.

We saw there was a good level of managerial oversight of the service, with regular senior meetings taking place, which dealt with specific issues and put in place solutions. For example, we saw one meeting highlighted an inconsistency with supervision and appraisals in previous years. The subsequent agreed action was to agree a new checklist and plan these meetings with staff at the start of the year. We saw this process was in place during our inspection.

We saw the registered manager had introduced methods to monitor the quality of the service in order to attempt to improve service provision. For example, they had introduced feedback questionnaires aimed to

seek ways to improve the induction new staff received. Likewise, we saw the registered manager undertook a range of audits, such as care plan audits and medicines audits. We saw, where discrepancies had been identified that the registered manager had ensured they were corrected and staff were informed regarding practices that needed to improve. We saw care plan audits had moved from happening on a quarterly basis the previous year to monthly this year. The registered manager told us this was to ensure staff were accountable and to ensure they spotted discrepancies or areas for potential improvements in people's care at the earliest stage.

We saw the registered manager currently undertook a training role in the service, but there were plans in place to give this responsibility to the training and development supervisor the service intended to recruit. This would take training responsibilities away from the manager and allow them to focus more on the quality of service provision. This demonstrated the registered manager and registered provider were aware of the risks of the service growing significantly and were beginning to put in place measures to manage this growth.

The registered manager undertook 'spot checks', which consisted of checking the care records staff had completed regarding people who used the service and accompanying the member of staff on a care visit. Staff we spoke with confirmed they had received 'spot-check' visits by the registered manager and welcomed this level of scrutiny. This demonstrated the registered manager took responsibility for ensuring people were cared for by staff who were subject to regular scrutiny.

The registered manager undertook surveys of people who used the service, staff and relatives. We saw the most recent results of these surveys and found them to be for the most part positive in their responses regarding the standards of care and the effectiveness of the registered manager.