Mariama Care Ltd

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

Summary of findings

Overall summary

This inspection took place on 23, 26 and 29 January 2018 and was announced. This inspection was the first comprehensive inspection of the service since it was registered with the Care Quality Commission (CQC) on 11 April 2017.

Mariama Care Ltd trading as Kangaroo Care is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults and people with a range of physical and sensory disabilities as well as people living with dementia. At the time of the inspection the service was providing care and support to 79 people.

This is the first time the service has been rated Requires Improvement.

Not everyone using Mariama Care Ltd receives the regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

A registered manager was in post at the time of this inspection. 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.

Risk assessments identified people's individual risks and provided clear guidance to staff on how the risks were to be managed in order to keep people safe and free from harm. We did find that for two people, specific risks that had been identified had not been assessed, however this was rectified immediately and appropriate risk assessments were put in place.

Since the registration of the service, the Care Quality Commission (CQC) had received a high number of safeguarding concerns which related to poor care, late visits, missed visits and issues with medicines administration. We discussed these concerns with the registered manager as part of the inspection process. The registered manager was able to give detailed information about each concern with actions that the service had taken to make the necessary improvements.

Although the service confirmed that sufficient staff were available to provide care and support, people and relatives feedback was that care staff were arriving late for their visits or were not staying the full allocated time. The service was working towards implementing a number of systems to address these concerns so that people's experiences of care and support would improve.

The service had safe recruitment processes in place to ensure that staff recruited and employed were assessed as being safe to work with vulnerable people. We highlighted to the registered manager that they must always ensure that satisfactory references, evidencing staff members conduct in previous employment

was obtained as well as any gaps in employment were explored and reasons for gaps clearly documented.

Safe medicines management and administration processes were in place to ensure that people received their medicines as prescribed. However, the registered manager needed to ensure that medicine audits were completed robustly to ensure that all discrepancies were identified and addressed.

Care plans contained pre-service commencement assessments confirming that the service always carried out an assessment of need prior to providing a service. People's choices, wishes, likes and dislikes were recorded as part of this assessment to ensure that care and support was planned and delivered to achieve the person's desired outcome.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Care plans were detailed, person centred and were reviewed on a regular basis. People had consented to their care and support and where people were unable to consent, documents confirmed that relatives had been involved in the decision making process where appropriate.

Care staff received appropriate and relevant training and support to enable them to deliver their role effectively.

The service ensured that all accidents and incidents were reported and recorded with details of the incident and the actions taken as a result in order for the service to learn and improve.

People, where required, were supported to access a variety of health care services to ensure that they received appropriate care and support. People were also supported with their nutritional and hydration requirements where this had been identified as an assessed need.

Most people and relatives were happy with the care staff that supported them and confirmed that their allocated care staff were kind and caring and were respectful of their privacy and dignity.

The service had processes in place which dealt with complaints and concerns. A log of each complaint was in place which detailed the nature of the complaint, how it was dealt with and the outcome for the person. The service listened and responded to people's concerns and complaints, and used this to improve the quality of care. The service learnt lessons and made improvements when things went wrong.

The registered manager had a number of checks and audits in place to oversee the quality of care and support that people received. However, on occasions these checks were not always robust enough and did not always identify some minor issues that we identified. In addition details of actions taken to address concerns were not always recorded.

Whilst we found that the service was not in breach of any of the regulations defined by the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, we found that there were a number of areas where the provider needed to ensure improvements were made and sustained. These areas of concern have been reported on within each of the key questions.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was safe; however, there were specific areas which required improvement by the provider.

Safe recruitment processes were in place. However, the provider needed to pay further attention to ensuring appropriate and satisfactory references were in place, criminal record checks were obtained and all gaps in employment for care staff employed were satisfactorily explored.

Feedback from people and relatives was that they felt safe with the care and support they received from care staff. However, concerns were expressed around the timeliness of visits and care staff not staying for the full allocated time of the visit.

A high number of safeguarding concerns had been raised against the provider relating to poor care. The service had taken steps to investigate these concerns in order to learn and make the required improvements.

Risk assessments assessed people's individual risks and provided appropriate guidance to staff on how to mitigate or reduce risk to ensure people's safety.

Safe medicine management and administration processes were in place to ensure people received their medicines as prescribed.

All accidents and incidents were recorded and reviewed to ensure that appropriate actions were taken learn and prevent re-occurrence.

Is the service effective?

Good

The service was effective. People's needs had been assessed prior to receiving care and support. This included people's choices and wishes on how they wanted to receive their package of care.

Care staff were supported through regular training and supervision.

People received the appropriate support with their nutritional and hydration needs as well as support with accessing health care services where this was an identified and assessed need.

Consent to care had been obtained in line with the principles of the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. Feedback from people and relatives was that care staff were kind, caring, courteous and polite.

Most people and relatives confirmed that they were involved with the planning of care and were able to express their views and make decisions about how they received their care and support as far as practicably possible.

People and relatives confirmed that care staff always delivered care and support whilst being respectful of their privacy and dignity.

Is the service responsive?

Requires Improvement

The service was responsive; however, there were specific areas that required improvement by the provider.

People and relatives felt that they did not always receive care and support that was responsive to their needs especially as they were not provided with a choice of carer or a regular carer.

The service used a number of care plan assessment documents that were on occasion completed inconsistently and were not always responsive to people's needs.

People and relatives knew who to speak with if they needed to complain or raise any concerns. Appropriate systems were in place to deal with and respond to complaints that had been raised.

Is the service well-led?

Requires Improvement

The service was well-led; however, there were specific areas that required improvement by the provider.

The registered manager had a number of systems in place to monitor and check the quality of care that people received. However, these were not always robust enough and did not identify some of the minor concerns that we found as part of this inspection.

People and relatives were regularly asked for their feedback on the quality of care that they received. The provider monitored and analysed the feedback so that the necessary improvements could be made.

The provider was aware of the issues and difficulties that the service had encountered since they had begun providing the regulated activity and were keen to engage and work with the necessary professionals to learn and improve the quality of care delivery.

Mariama Care Ltd

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.

The inspection was prompted in part by the receipt of a high number of safeguarding concerns since the service began providing the regulated activity of personal care. As part of this inspection we looked at each of the concerns and the actions taken by the provider to assess the likelihood of any current risks occurring, and the impact on people using services if they do. We also wanted to be assured that the provider had mitigated these emerging risks appropriately and made the necessary improvements.

This inspection took place on 23, 26 and 29 January 2018 and was announced. We gave the service 48 hours' notice of the inspection visit because it 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.

Inspection activity included visiting the office to look at records, visits to people's homes with their permission and telephone calls to people, relatives and care staff. We visited the office location on 23 and 26 January 2018 to see the manager and office staff; and to review care records and policies and procedures. On 26 January 2018 we visited four people at their homes with prior consent and looked at their care records contained at their home. On 29 January 2018 we telephoned care staff.

Before the inspection, we checked for any notifications made to us by the provider and the information we held on our database about the service and provider. Statutory notifications are pieces of information about important events which took place at the service, such as safeguarding incidents, which the provider is required to send to us by law.

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

The inspection was carried out by two adult social care inspectors and two Experts by Experience, which are people who have personal experience of using or caring for someone who uses this type of care service. Their involvement was limited to phoning people using the service and their relatives to ask them their views of the service.

During the inspection, we spoke with nine people using the service, 12 relatives, seven care staff, two office staff members, the training provider and the registered manager.

We reviewed the care records for 11 people receiving a service to see if they were up-to-date and reflective of the care which people received. We also looked at personnel records for ten members of staff, including details of their recruitment, training and supervision. We reviewed further records relating to the management of the service, including complaint and safeguarding records, to see how the service was run.

Requires Improvement

Is the service safe?

Our findings

People and relatives all confirmed that they felt safe with the care and support that they received from care staff. Feedback from people when asked if they felt safe included, "Yes, I do", "Yeah I am happy but not happy at the times they come" and "Yes. Well it is because if I don't like them I can put them out if I wish." Comments from relatives included, "Oh yes she feels safe", "Yes, he is comfortable" and "He feels safe with the person allocated to him."

The provider was registered with the Care Quality Commission on 11 April 2017. The CQC normally would inspect a newly registered service within 12 months of the date of registration. However, to date, since the service had begun providing the regulated activity of personal care, they had received approximately 16 safeguarding concerns raised by the local authority relating to poor care, lateness of visits, carers not staying the full allocated time and medicine administration which in part led to us to inspect this service.

We discussed these concerns with the registered manager who went through each concern and provided detailed information as to what actions had been taken to resolve the concerns and improve the delivery of care. Records confirmed that each concern had been internally investigated with details of the provider's findings and the outcomes according to the providers safeguarding policy. The registered manager and all care staff clearly understood their responsibilities around safeguarding people from abuse and were keen to ensure that people were kept safe at all times.

Care staff that we spoke with were able to describe the different types of abuse and the steps they would take if any concerns were noted. One care staff told us, "Abuse includes emotional, physical, institutional. I would go straight to the manager and a safeguarding would be raised." A second care staff stated, "It is our responsibility to keep our clients safe. I would straight away call the office and they would direct me on what to do." Care staff knew the meaning of the term 'whistleblowing' and named a variety of external agencies that could be contacted if they had concerns including the CQC, local authority and the police.

The registered manager confirmed that they currently had approximately 25 care staff delivering care and support out in the community. They believed that they needed to recruit an additional four to five care staff members to ensure sufficient staffing in order to deliver safe care and support to all the people they supported. However, feedback from people and relatives was that care staff were not punctual, did not stay the full allocated time per call, they did not always receive regular care staff and that they were not informed if care staff were running late.

Out of the nine people and 12 relatives that we spoke with four people and nine relatives told us that they had issues with the timings of the calls and that they did not always receive a regular care staff. Comments from people included, "I never knew what time they are coming", "They used to come at 11am or 12. They can't come before the nurse who comes at about 9am. I don't want them to come so late" and "I just have morning and afternoon and evening. There is no specific time." Relatives told us, "At the beginning it was awful. So for the last month we have had the same person and arriving at 07:30am. Prior it was a different one every day. Last week I got a call that they had no one to come that day as carer was not well" and "Most

times they are late and they don't stay for the full time. I have complained several times. This week is better." Only one person and two relatives confirmed that they received regular staff who were always on time and most people and relatives did comment they had seen some improvements recently.

We looked at rotas for ten care staff members to see whether sufficient travel time had been allocated between each call. Records confirmed and care staff told us that their rotas always incorporated travel time between calls but that other factors such as traffic and travelling by public transport impacted on them arriving on time to their calls. Care staff knew that they were to inform the office whenever they were running late. Other systems that had been put in place to ensure improved timekeeping included allocating staff within small geographical areas, to minimise travel time, and allocating car drivers to a second care staff to deliver care to all people who required two care staff.

The registered manager was very aware of these concerns and had also implemented an electronic monitoring system whereby care staff were required to log in and out when attending to a care call through their mobile phones. The system also alerted the office when a care staff had not logged in to the system within 30 minutes of time the care call was due. This system had been in place since December 2017 and the provider had noted improvements but recognised that further improvements were needed. The registered manager was considering reducing the alert time from 30 minutes to 15 minutes so as to respond more promptly in addressing lateness.

As part of the care planning process, the service identified and assessed risks associated with the person's care and support needs. This included generic assessments which included assessing the environment, premises and moving and handling. People's individual risks were also assessed and included risks of pressure sores, choking, use of a colostomy bag, malnutrition, falls and not taking medication. Each risk assessment identified the issue and gave guidance to staff on the nature of the concerns and the actions to be taken to manage or mitigate the risk. Risk assessments had been reviewed every three months or sooner if people's needs had changed.

However, we found three people's care plans that had not assessed certain risks associated with the use of a catheter, risks associated with specific blood thinning medicines and risks associated with health conditions such as epilepsy and diabetes. We highlighted this to the registered manager who immediately addressed these issues and devised risk assessments for these identified areas. The risk assessments were sent to us immediately after the inspection.

Care staff that we spoke with knew the people they supported and were aware of the risks associated with the person's care and support needs. One care staff told us, "I read the care plan. I also read the previous carers notes and ask questions." Another care staff stated, "The care plans tell you what the risks are for the person."

The service had systems and processes in place to ensure the safe administration and management of medicines. Care staff supported people in their own homes with prompting and administration of medicines and completed Medicine Administration Records (MAR) confirming this had been done. Where people were assessed to require support with medicine administration, a consent form had been duly completed and signed either by the person or their relative giving permission to receive this support. The consent form also included a list of the person's medicines, the dosage and the times the medicines were to be administered. Attached to this was a monthly MAR which care staff were required to sign. We looked at six MAR's which confirmed that staff were completing these forms and minimum gaps in recording. However, on one MAR we identified one gap in recording and that care staff were signing to confirm medicines had been administered on the 31st of every month even though some months there are only 30 days in the month.

Whilst the registered manager audited all completed MAR's to ensure that they had been appropriately filled in by care staff, the audits failed to identify the minor issues we identified as part of the inspection. We highlighted this to the registered manager and guided them to look at the National Institute for Health and Care Excellence (NICE) guidelines on medicine management and administration for services providing care in the community to ensure that they were following best practice.

Records confirmed that the provider followed appropriate processes when recruiting staff to work with vulnerable people. We saw a number of checks that had been completed which included a criminal records check, identity checks and references confirming conduct in previous employment. However, we found on six out of the 11 care staff files we looked at, whilst character and factual references that only confirmed staff members previous dates of employment were available, references from previous employments confirming the person's conduct had not been received or obtained. We also saw on some files that gaps in employment had not always been explored with the care staff. We also noted that for three staff employed who had brought with them a criminal records checks, completed by a previous employer, the provider had not always carried out their own checks, especially where the check completed was over three months old. The registered manager confirmed that they were in the process of completing online criminal record checks and we saw evidence that this had been carried out for some staff. We highlighted these concerns to the registered manager and guided them to always ensure they follow Schedule 3 of the Health and Social Care Act 2008 which gives clear guidance to the evidence required when recruiting staff to work with vulnerable adults.

The service recorded and monitored each accident or incident that care staff reported that had taken place in a person's own home. We saw examples of completed forms with details of the incident and the actions that were taken. We saw a variety of incidents that care staff had reported which included unexplained bruising, falls, people refusing personal care and people not at home at the time of the care visit. The registered manager completed monthly audits of all accidents and incidents with a view analysing each incident, identifying any patterns, learning and implementing any improvements where necessary. We also saw a number of communications between the service and local authorities where concerns had been escalated to ensure that people's needs were reviewed as a result of the incident.

The service ensured that a variety of Personal Protective Equipment (PPE) was always available and accessible to staff. Adequate supplies of personal protective equipment (PPE) such as gloves, aprons and shoe covers were available for staff to collect from the office. Care staff had been trained in infection control and care plans also guided staff on when to use PPE appropriately.

Good

Is the service effective?

Our findings

People and relatives generally felt that care staff that supported them and their relative were appropriately trained and skilled to deliver effective care. Comments from people included, "Yeah, I think so", "I don't know. They are the youngest. I don't think they can do the work. I tell them what to do and they still can't do it", "Yes, I think so" and "Yes." Feedback from relatives included, "As far as I know they do", "No, washing seems to be too quick. How can you give a bed bath in 12 minutes? The average is 15 minutes" and "I don't know. They don't know much about her. They support her to a certain extent."

Records confirmed and care staff told us that they had received an induction, training and underwent shadowing before they started their employment with the service. This included training in topics such as safeguarding, moving and handling, medicine administration and first aid. In addition care staff were also observed on their competencies in specific areas such as moving and handling and medicine administration.

All care staff had also been enrolled to complete the care certificate. The care certificate is a set of standards that care staff are expected to meet in order help them understand good care. Care staff also confirmed that they felt enabled to request any specialist training that they identified they needed to carry out their role. Comments from care staff included, "They gave me training, did induction with me and shadowing as well", "I received induction and she [registered manager] trained me as well. I had already done the training but [registered manager] told me I had to do it again" and "Induction and training was good. I would not need to ask [registered manager] for any training as she is asking us to do everything."

We saw records confirming that all staff received regular supervision and care staff confirmed this. Care staff also told us that they could speak to the registered manager at any time to discuss any concerns or issues. Care staff found supervision useful and told us that they discussed a variety of topics such as issues, concerns, people they support and training. The service was yet to complete appraisals as staff had not completed a full year of employment at the time of this inspection.

The service completed an initial needs and risk assessment prior to the provision of care and support. This assessment noted people's needs, choices, wishes, likes and dislikes on how they wished to be supported. Following this assessment a care plan was compiled which gave detailed information on the person, the timings of the call, the tasks that needed to be completed and any concerns or risks that care staff needed to be aware of. Care plans were reviewed on a three monthly basis or sooner where changes were noted.

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. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS. We checked whether the service was working within the principles of the MCA.

We found that the service did follow the principles of the MCA. Care plans recorded people's capacity and the ability to make certain decisions and where possible people had signed their own care plan consenting to the care and support that they received. Where people lacked capacity, this had been clearly documented and care planning had taken place with a relative or friend involved in the process. People and relatives confirmed the care staff did seek consent before supporting them or their relative and always offered choices. One relative told us, "My mum does not have capacity. They always talk her through what they are doing."

The registered manager and all staff clearly understood the principles of the MCA and were able to specifically relate this to the care and support that they delivered. Care staff were able to describe how they obtained consent to care and the ways in which people were supported to make their own choices and decisions. Feedback from care staff included, "If you are working with a person who has dementia you have to be patient, would try to explain choices and speak with the family to see if they can help", "We have to encourage them [people] by talking to them, repeating things until they understand. Sometimes people understand body language. We have to ask permission and give them a few choices" and "I would explain to them [people] what I am doing. I would give them choices for instance like their meal and what they would like to eat."

Not all people receiving the regulated activity of personal care received support with their meals. However, where this was an assessed need care plans provided details in relation to the support that people required, their likes and dislikes and any cultural preferences and wishes. Where people had specialist requirements including specialist diets or support with eating their meal this was clearly documented within the care plan. Most people and relatives confirmed that they were offered choice and were supported with their meals where this was an identified need. Feedback we received included, "They [care staff] make sure she eats or has something prepared for her meals", "No, but it is a requirement as per the package but it is not happening. I don't know why it is not happening" and "Yes, they make teas in the morning and the evening." We also observed, whilst visiting people at their home, that where care staff had completed their care visit, people had been left with adequate refreshments which was within easy reach for them to access.

The registered manager confirmed that people were only supported with accessing external health care services where they were requested to do so. For most people receiving a service, family members and relatives were involved in supporting the person with all of their health care needs. However, we saw records confirming that where concerns were noted by the service and care staff about people's health care, appropriate referrals had been made to the relevant health care professional. We saw examples of referrals to the GP, occupational therapist and calls made to emergency services. People and relatives did not express any concern in this area and were confident that care staff would act accordingly where health care concerns were noted. One relative commented, "They [care staff] are quite concerned about her health."

Care staff completed daily recording sheets after each care visit had been completed. Information recorded included the tasks undertaken, whether the person had been supported with their medicines and what the person had eaten or drank. Any significant incidents or accidents were also recorded so that information could be passed over to other care staff visiting the person especially where specific actions needed to be

followed up. The registered manager also showed us records evidencing how they worked in partnership with other healthcare professionals such as social workers and GP's especially where a person's needs had changed.

Good

Is the service caring?

Our findings

Most people and relatives that we spoke with told us that they found the care staff that supported them to be kind and caring and that they were treated with dignity and respect. Comments from people when asked if the care staff that supported them were caring included, "I would say so yes, I am very happy with them. They are always polite and courteous", "They are caring. I talk to them. They say they must go as they have other clients. They could stay longer as I should have a whole hour with them" and "They [care staff] are kind and caring." Feedback from relatives when asked the same question responded with comments including, "Well [name of care staff] is alright. I have never heard her complain about them. The problem is the time keeping", "Yeah they are kind and try to make my father comfortable. They are jolly" and "As far as I know."

People we spoke with and visited told us that they had developed positive relationships with care staff especially where they received regular care staff on a daily basis. One person told us, "We always have a laugh and joke together." Another person said, "They [care staff] know what they are doing. I never have to tell them anything." One relative commented, "They [care staff] talk to her and tell her what they are doing. They are very friendly with her."

Most people and relatives told us that they had been involved in the planning and delivery of care from the time it was identified that they required care and support. Assessments either involved the hospital from where they were being discharged, healthcare professionals and/or Mariama Care Ltd. People and relatives knew the care plan that had been developed was available at their home which care staff used for reference and recording on a daily basis to ensure people received care and support as per their needs and choices.

People and relatives told us that they were always treated with dignity and respect. One person told us, "Yes, they always knock on my door and introduce themselves before coming in." One relative said, "Personal care is very respectful." Care staff were able to clearly demonstrate how they ensured that people's privacy and dignity was always maintained with examples on how they did this. Feedback from care staff included, "When I approach people I always make them feel wanted, like they are my family, I tell them my name and have a chat with them", "We draw the curtains and we use a towel to cover the client when supporting them with personal care" and "The first thing I do is an assessment of the house. I respect their house, give them [people] choice and protect their dignity."

Care staff also tried to ensure that they promoted people's independence where possible. One care staff explained, "Everyone wants to be free and be able to take their own decisions. When you enter the service users home let them tell you what they want and what to do. You are going to respect that." Another care staff said, "I always try to encourage them. Try and explain things and praise them."

The service ensured that people received care and support that reflected their diversity which included recognition and acknowledgement of their faith, culture, religion and sexuality. One senior staff member told us, "We support people regardless of their sexuality. We discourage carers to make any discriminatory remarks and we always stress about race and equality." One care staff told us, "It makes no difference to me. We are living in a huge world. We respect everyone and we respect each other." Care plans noted what

people's faiths were so that staff were aware if there was anything that may relate to care being provided and a person's faith.

Requires Improvement

Is the service responsive?

Our findings

Most people and relatives confirmed that they generally received care and support that was responsive to their needs. However, issues with timekeeping, not receiving a phone call when care staff did not arrive for a scheduled call and people not having their choice of care staff were common themes that were brought to our attention as part of people and relatives feedback. People when asked if they get a choice with the care staff that supports them told us, "No I don't. I get whoever comes. Occasionally they send the regular people" and "No I am not asked. I don't mind. There is always someone who comes." Concerns that have been identified have been reported on in more detail under the 'Safe' section.

Care plans were detailed and person centred and included detail about people's likes, dislikes, choices and wishes. However, we found that care plans contained a number of lengthy care plan assessment templates that were only partially being completed, with on occasions, inconsistent information contained within them. This included a lengthy support planning pack which looked at support needs, mental health assessment and premises and environmental risk assessments. Some of the information contained within the support plan pack had already been incorporated in detail within the needs and risk assessments and care plan document.

We highlighted this to the registered manager and questioned the purpose of this document especially in regards to some inconsistent information that was recorded which may have meant that care staff may not have had the relevant and most appropriate information about the person they were supporting in response to their needs. The registered manager stated that the reason for the use of these documents was that she believed that as part of the CQC registration process she had presented these templates that she planned to use as care plan documents and believed that this could not be changed. We informed the registered manager that this was not case and that they could use any template that the service felt appropriate to use when recording people's support needs and requirements effectively and responsively.

We also noted that some language and incorrect spelling used within care plans and the recording of people's needs was not always appropriate and person centred. We asked the registered manager to review the examples that we gave in order to make the necessary improvements.

People and relatives confirmed that care staff did listen to them and provided care and support that was responsive to their needs. Care staff demonstrated a good understanding of person centred care and clearly knew the needs of the people they supported. Comments from care staff included, "People are different, totally different, different choices, needs are also different" and "What I do for one person is not the same for another person. Everybody is an individual."

People and relatives told us that they knew who to speak with if they had any concerns or issues to raise and most times the person they spoke with dealt with the concern. However, some relatives did comment that they felt that their concerns and complaints were not always taken seriously. Comments from people included, "I have their telephone number. Yes I have once or twice. They don't keep to times and what they are supposed to be doing. They have improved", "Yes there is a complaints procedure I can use, but I have

never had to use it" and "I would call [name of staff]. Find her very pleasant."

Feedback from relatives was, "[Name of staff] will pass it onto the management. I haven't had that many reasons to complain", "She has complained about the time, but they still come in late" and "When I have complained before, they said they will stick to the time. I don't know if they take the complaints seriously."

We saw that the registered manager kept records of each complaint which included the details of the complaint and the actions taken. Where appropriate the registered manager had also written to the complainants with the findings of their investigation into the complaint and an apology for any inconvenience caused. The registered manager was well very aware of the concerns and complaints that had been raised and the emerging themes which the service was learning from and implementing processes for improvement.

Requires Improvement

Is the service well-led?

Our findings

The provider had a number of systems in place designed to check and monitor the quality of care that people received with a view to learning and implementing the required improvements. These included medicine administration record checks, daily observation record checks, care plan and medicine audits and spot checks. However, we found that these checks did not always identify some of the concerns that we identified as part of the inspection process. This included for example the concerns we noted around medicines recording where care staff were signing for 31 days of the month when the month only had 30 days. Where issues were identified by the provider's internal processes, details of the actions taken and timeframes within which actions were to be completed were not always recorded.

The service ensured that people and relatives voices were always listened to through monthly quality monitoring telephone calls and visits. Questions that people and relatives were asked were around the quality of care that they received with the opportunity to make additional comments about any improvements that could be made. One relative had written, 'The carers are very good and see to my [relative] needs. My only complaint is care provided in the weekends is very erratic. Most times carers arrive very late and on occasions not at all. Also it would be better if we had the same carers daily instead of constantly changing. Other than that it is fine.' However, where any concerns or areas of improvement had been recorded, details of actions taken had not been recorded.

This comprehensive inspection identified a number of minor concerns around the completion of risk assessments especially where people were assessed with significant health conditions, people and relatives complaints about the timeliness of scheduled care calls, completion of and recording within people's care plans and discrepancies with the way in which the provider completed checks for newly recruited care staff. These issues were brought to the attention of the registered manager during the inspection. The registered manager acknowledged the issues that we identified and was keen to engage and work with the necessary professionals to learn and improve the quality of care delivery.

We saw evidence of the provider working in partnership with the local authority to make the necessary improvements especially in relation to the complaints and safeguarding concerns that had been received. The registered manager told us, "The quality team are very good and very supportive. They have given me the opportunity to open up to them to improve. I knew that things were not right. They have been very supportive."

The provider also engaged with the local authority in attending provider meetings where providers from the locality were invited to engage with the local authority and each other in order to learn and share experiences and practises. The registered manager also explained that they were working in partnership with a friend who was also a provider and another individual who was mentoring the registered manager and the service with a view to learning and improving service provision.

People and relatives confirmed that they knew the manager of the service and felt confident in contacting them when required. Comments from people included, "I always speak to [name of staff]. [Name of

registered manager] is the manager. She is fine" and "Yes [name of staff] and I could always speak to [name of registered manager]." Relatives comments included, "[Name of registered manage] I have only met her once. She seems okay" and "Yes [name of registered manager]. She made a home visit before the carers came to visit [relative]."

Care staff were also positive about the registered manager and told us that they felt well supported in their roles. Feedback from care staff included, "She [registered manager] is very, very good. Ready to do anything", "Very, very good manager. If you do something wrong she tells you" and "She [registered manager] is a very honest person. She is always willing to learn. Not confrontational. If I do something wrong she will tell me. We work well together and I feel supported."

We saw records confirming that the registered manager held staff meetings every two months. This allowed the registered manager to provide staff with information about the service, reminders about best practice and for staff to raise any concerns or discuss ideas and feedback about the care they provided. Agenda items included people's well being, medicines management, electronic monitoring and record keeping. One care staff said, "It's about going forward and what to do to improve."