Brookleigh Caring Services Limited

Brookleigh Caring Services

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?	**Good**

Summary of findings

Overall summary

This inspection took place on 19 January 2016. The inspection was announced which meant that we gave 48 hours' notice of our visit. This was because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available.

We last inspected the service on 20 June 2014 and found that the service was not in breach of any of the regulations inspected at that time.

Brookleigh Caring Services is a domiciliary care agency registered to provide personal care to people in their own home. At the time of our visit 309 people were using the service for the provision of personal care.

The service had a registered manager in place. 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.

We saw that some individual risk assessments were in place and that they covered the key risks specific to the person. These included areas such as risk of falls and moving and handling, but they did not always contain sufficient detail. Some risks had been identified but no corresponding risk assessment was in place. We looked at care plans and found that they lacked sufficient detail to be suitably person centred. We have made a recommendation about care planning.

Although staff were observed administering medication safely, records were not always correct. We have made a recommendation about the management of records for medicines.

People told us they felt there were sufficient staff and although call times were not always strictly adhered to, when staff were running late people were contacted to advise them of the delay. The service had no recorded missed calls.

Staff received appropriate training and had the skills and knowledge to provide support to the people they cared for. New staff underwent a comprehensive induction and shadowed a more experienced colleague until they were judged competent to carry out calls alone.

There were systems and processes in place to protect people from the risk of harm. Staff were able to tell us about different types of abuse and were aware of the action they should take if they suspected abuse was taking place. Staff were aware of whistle blowing procedures and said they felt confident to report any concerns without fear of recrimination.

Appropriate environmental checks had been done on people's homes to ensure the health and safety of staff and the people they cared for.

Staff were knowledgeable about the people they provided care to and were respectful of people's privacy and dignity. People who used the service said that staff were caring and kind. People told us that staff encouraged them to be independent and they were happy that staff took time to chat with them.

People were supported to maintain good health and to access health professionals when needed.

We found that safe recruitment and selection procedures were in place and appropriate checks had been undertaken prior to staff starting work. However we found there to be some documents missing from recruitment files, for example health monitoring forms and some gaps in employment were not fully explored. These omissions were not widespread and did not impact on the overall safety of the recruitment process.

Staff received regular supervision and annual appraisals to monitor their performance.

Staff received training on the Mental Capacity Act (2005) and demonstrated an understanding of the requirements of the Act.

We saw that, where appropriate, people were provided with a choice of food and drinks to help ensure their nutritional needs were met.

There was a complaints procedure in place and people we spoke with were aware of how to make a complaint if necessary. We saw evidence that complaints had been investigated appropriately but that outcomes had not been recorded.

Staff meetings were held regularly and were seen as a robust method of communication.

There were systems in place to monitor and improve the quality of the service provided and the registered manager and other senior staff audited paperwork and conducted spot checks on staff practice regularly.

We found the provider was breaching one of the Health and Social Care Act 2009 (Regulated Activities) Regulations 2014. This related to the safe assessment and mitigation of risk. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Medicines were administered safely but we saw that medicine records were not always correct.

Individual risk assessments were in place but needed more detail. Some identified risks had no corresponding risk assessment in place.

Evidence of safe recruitment practice was seen but details were missing from some files.

People were kept safe from harm by staff that had a good knowledge of how to look for signs of abuse and report concerns accordingly.

Is the service effective?

Good

The service was effective.

People were cared for by staff who had received appropriate training.

Staff received training on the Mental Capacity Act (2005) and understood how to apply this in practice.

People were supported to access healthcare and their nutritional and hydration needs were met.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who took time to deliver care in a friendly way.

Staff knew how to treat people with respect and dignity.

People were encouraged to be independent where possible and given the right level of support when they needed it.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People were involved in decisions about their care and how they wished to be supported.

People had care plans in place that addressed their support needs but these did not contain sufficient detail.

The service had an up to date complaints procedure and people we spoke with knew how to make a complaint or raise a concern however none of them had felt the need to do so.

Is the service well-led?

Good

The service was well led.

Staff spoke positively about the support and recognition they received from management.

Staff meetings were held regularly and were seen as an effective method of communication.

The registered manager carried out regular quality assurance checks and sent through notifications of incidents to the CQC in a timely manner.

Brookleigh Caring Services

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 January 2016 and was announced. The registered manager was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that staff would be available.

The inspection team consisted of two adult social care inspectors and one pharmacy inspector. Three experts by experience telephoned people in their own homes to gain their views of the service. These calls took place between 18 and 21 January 2016. An expert-by-experience is a person who has personal experience of using or caring for someone who uses a service, on this occasion a domiciliary care service.

Before the inspection we reviewed all of the information we held about the service, such as notifications we had received from the service and also information received from the local authority who commissioned the service. Notifications are details of changes, events or incidents that the provider is legally obliged to send us within a specified timescale.

The provider was not asked to complete a provider information return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

During our inspection we spoke with one of the directors of Brookleigh Caring Services Ltd, the registered manager, two care workers and one senior carer. During and after the inspection visit we undertook phone calls to 27 people that used the service and 12 relatives of people that used the service. We emailed the service a set of questions to be passed on to all staff and received 11 responses. We also spoke with one external healthcare professional.

We reviewed the care records of six people that used the service, reviewed the records for six members of

staff and records relating to the management of the service.
We also looked at the medicine records of people who used the service. We spoke with staff about medication and reviewed the provider's medication policies.

Of the 11 medication records we looked at, we visited four of the people in their own home to make sure that appropriate arrangements were in place to manage medicines safely.

Requires Improvement

Is the service safe?

Our findings

Risks to people using the service and to the care workers who supported them were assessed. This included environmental risks and risks arising from the individual support needs of people, such as falls and manual handling. We saw that individual risk assessments on people's care files did not always contain sufficient detail. For example a risk assessment for bathing said that staff were to ensure the water was the correct temperature but did not state what that was; nor did it state whether the service user was able to be left alone to wash independently or needed help or supervision. Some areas where risk had been identified did not have a corresponding risk assessment. We saw that one person used a stair lift and also needed a walking stick when outdoors but there were no risk assessments for this

There were environmental risk assessments in place for each person's home. These included areas such as fire safety, access to premises and isolation points for water, gas and electricity. We saw that these were not always fully or correctly completed. One risk assessment regarding the equipment used by staff did not show that the kettle was used and yet the person using the service was provided with hot drinks. Where boxes said "if you have ticked yes please state reason why" no information was recorded when yes had been ticked. We saw that one person had a dog and whilst this was noted on file there was no risk assessment in place for this. We discussed this with the registered manager who confirmed that in fact the person now had two dogs and said they would arrange for a risk assessment to be put in place immediately. The absence of comprehensive, detailed risk assessments meant that the provider was not effectively identifying or mitigating risk.

This was a breach of Regulation 12 of the Health and Social Care Act (2008) (Regulated Activities) Regulations 2014.

We looked at how the service managed medicines. People who received support with medicines said they felt this was done properly and recorded correctly. One person told us, "The carers come in at the same time each day and make sure I get my tablets at the same time."

We looked at the medicine records of eleven people who used the service. We spoke with staff about medication and reviewed the provider's medication policies. Of the eleven medication records we looked at, we visited four of the people in their own home to make sure that appropriate arrangements were in place to manage medicines safely.

The provider had a detailed medication policy in place which stated and explained the different levels of medication support that were provided. We saw that the level of support identified in the risk assessment mostly matched the level of support given for all four people we visited. This was also the same level of support recorded on the Medicine Administration Chart (MAR) by staff. For one person we visited the medication risk assessment stated the person required their medication to be administered by staff but we saw on the MAR that one medicine was left out for the person to take later. No risk assessment had been completed so that the provider could not be sure that the individual knew when and how to take this 'left out' medication and that they could manage it safely.

Care plans we reviewed contained lists of people's medicines and also information about where people kept the medicines, how they should be administered and what time they should be taken. However we found that the information on the current medication list was not always up to date and accurate.

People told us they received all their prescribed medication on time and when they needed it. We observed medication being administered to people safely.

Most medicines were supplied in a monitored dosage system. This was used correctly to support the safe administration of medicines in the home. However, we found that where the non- administration code 'o' was used, care staff had not recorded the reason for this as detailed in the medication policy.

For one person whose medicines were administered from the original boxes supplied by the pharmacy. The medicines were accurately recorded.

We were told that there was a system to record when care staff had applied creams and ointments. This included a body map which described to staff where and how often these preparations should be applied. This system was in place to help ensure that people's prescribed creams and ointments were used appropriately. We found that for two people we visited, who were both having cream applied by staff, this guidance was missing. Staff told us they were still working on improving these records and ensuring they were always completed.

We looked at the current medicines administration record for one person prescribed a medicine with a variable dose, depending on regular blood tests. Written confirmation of the current dose was kept with the person's medicines administration record (MAR) sheet. Care staff were able to check the correct dose to give. Staff had recorded that this medicine had been given correctly. Arrangements were in place for the safe administration of this medicine.

We were told that care staff were given medication training and were shown certificates of medication training for four members of care staff. We also saw that care staff were assessed by a supervisor to make sure that they were following guidance.

We recommend that the registered manager consults national guidance to ensure best practice is followed in respect of medicines records.

People we spoke with told us they felt safe being cared for by the service. One person said, "I feel very safe all the time when carers are here." Another person told us, "the staff are really friendly and even if they are new I feel safe."

A relative we spoke with told us, "The shower is done well but if they are not to her liking she will say don't do it. Some just put her more at ease than others. She's certainly safe with all of them. There's nothing nasty. Some just relate better to her."

We saw the service's safeguarding policy which described how the service operated a zero tolerance policy towards abuse. The policy stated that the service would take every possible action to prevent abuse and to deal with it promptly and effectively if it occurred, or was alleged. The service had reported safeguarding concerns appropriately to the CQC and the local authority safeguarding team.

Staff had all received up to date safeguarding training and demonstrated a good understanding of safeguarding issues, including how to recognise signs of potential abuse and who to report concerns to. One

member of staff told us, "some people can change from being happy to sad or moody, I would report it to my senior initially but would go to social service or the police if I had to." Another said, "I would look at the way they act. I know my service users inside out. If they went from happy-go-lucky to withdrawn I would report it straight away to my manager."

The service had a whistleblowing policy that was available to staff. Whistleblowing is when a person tells someone they have concerns about the service they work for. Staff we spoke with knew about the policy and felt confident in whistle blowing without the fear of recrimination. One member of staff told us, "My first priority is myself and the service users so I would report, or whistle blow if I had to, I would have no problem doing so."

People we spoke with told us that staff washed their hands before handling food and used personal protective equipment (PPE), such as gloves and aprons, appropriately. Staff confirmed that there was a good supply of PPE available to them.

Some people we spoke with told us that staff sometimes arrived late to provide care, or at a different time to that agreed. Comments included, "They are very hit and miss with their times", "She arrives late, it happens a lot" and "My problem is they arrive too early! They are here at 8:30am and it should be 10:00am. I think they have someone else in the area and want to link us up." However, other people told us that staff arrived on time. They said, "They turn up on time 99% of the time" and "yes, they are usually on time."

The client visit sheets we looked at showed that calls were not always made at the scheduled time but the majority were between 15 to 30 minutes either side of this time. The service had a 15 minute tolerance for late calls to take into account calls running over or travel taking longer. One member of staff we spoke with told us, "Travelling time between calls can be a problem. Where a problem has been identified the coordinators have done what they can."

The service used a live data computer system to monitor calls. Staff used their mobile phone to swipe in and out of a person's home. This system flagged up if a member of staff did not arrive at a call once the 15 minute tolerance window had passed. The receptionist monitoring the system would then call the member of staff to check on their progress and contact the next person expecting a visit in order to keep them informed. One person we spoke with confirmed that this procedure was being followed. They told us "They turn up on time and if not they let me know." The live data system was constantly monitored and ensured that if a member of staff was unable to make a call another person would be sent. This high level of monitoring meant there were no missed calls recorded by the service.

We asked people if they had the same staff regularly providing their care. People told us, "We usually have the same staff but they didn't inform me they would change when I came out of hospital", "We have settled now to the same three or four, which is good" and "The two I have are marvellous. They are the regulars. They are absolutely marvellous." The registered manager told us, "Staff are always introduced to new customers."

We discussed staffing levels with the registered manager and they said that whilst there were enough staff to cover the calls it could be difficult to accommodate requests for specific times. Most people tended to want their calls at the same time which the registered manager told us was not possible or practical in terms of staffing, they recognised that in these circumstances it was about managing people's expectations and doing their best to reach an acceptable compromise. We were also told that zero hours contracts meant that recruitment and retention of suitable staff was an ongoing challenge and that at times this made it difficult to provide consistency in the staff who provided care to an individual but they aimed to do this

wherever possible. The service did not use agency staff.

We looked at the recruitment records of 6 staff. Pre-employment checks had been undertaken prior to staff starting work, including the obtaining of at least two references. However there were some gaps in employment that weren't fully investigated, there were health declarations missing from files and there was no identification on one of the files we looked at. These omissions were not widespread and did not impact on the overall safety of the recruitment process. Disclosure and Barring checks had been carried out for all staff. The DBS carry out a criminal record and barring check on individuals who intend to work with children and/or vulnerable adults. This helps employers make safer recruiting decisions and also prevents unsuitable people from working with children and vulnerable adults.

Good

Is the service effective?

Our findings

People we spoke with told us they thought that staff had received relevant training to meet their needs. One person said, "All the carers are very well trained, the ones who come to me have an NVQ." Another person told us, "The regular ones are well trained and they put a new person on with them to learn" but added "It is not so good when they send new ones on their own."

Staff spoke positively about their training. They also told us they felt able to ask for any additional training they needed. One member of staff said, "I've done quite a lot of training since I started. Induction was very comprehensive and I got chance to shadow my mentor and other carers too."

Newly employed staff completed a comprehensive induction. The induction process included areas such as privacy and dignity, moving and handling, medication awareness and safeguarding. New staff then shadowed a more experienced colleague for three shifts, or until they felt confident to work alone. If staff required more shadowing, then this was factored in until both the new staff member and their mentor were confident that they were safe to cover calls alone. New staff also completed the Care Certificate, which was introduced within the care sector to ensure that workers had the opportunity to learn the same skills, knowledge and behaviours to provide compassionate, safe and high quality care and support.

We looked at the staff training matrix and saw that most staff were fully up to date with mandatory training, including safeguarding, manual handling and first aid. Mandatory training is training that the provider thinks is necessary to support people safely. Where training was not up to date the registered manager confirmed that dates had already been arranged to cover this. Specialist training had also been delivered covering topics such as dementia awareness, emergency stroke awareness and diabetic emergency. During our visit a number of staff were in the office to attend an autism training course that had been arranged as a result of the service providing care to a person with autism.

Spot checks were undertaken by senior staff and management to monitor the standard of care being delivered and the competence of staff. This was done by making observations in people's homes every two to three months.

We saw evidence that staff received regular supervisions every 8 weeks, along with annual appraisals. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The records we saw showed that these sessions covered areas such as training needs, any additional support needed and discussion around what staff thought they were doing well. Staff felt that these meetings were useful but also said that they were able to go into the office to speak to someone at any time they had a problem.

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 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. All staff had received training on MCA and staff demonstrated an understanding of the basic principles of the Act such as when a best interest decision would be necessary.

We saw evidence of consent in people's care files. Consent documents were signed by the person using the service. For example, we saw a record to show that one person had been asked for their consent to have information passed to the falls team.

Daily notes were made by staff during calls and these sheets were kept in people's homes. This should have provided an effective form of communication between staff as well as a record of care delivered during visits but the documents we looked at were handwritten in such a way that they were not always legible. Those entries we were able to read did not contain sufficient detail to make them an effective working document. Staff had noted things such as, "[person's name] fine, social interaction completed."

Relatives reported being happy with the information they received from the service. One relative told us, "They are very good and they are doing what I want for Mum. If there are any queries they let me know. It's reassuring for me as well, they will let me know how she is and keep an eye on things."

We saw that where people had reported being unable to read the rotas sent out due to eyesight problems they had been produced in large print to address this.

People were supported to maintain good health and to access health professionals when needed. One person told us, "My carer recently phoned the emergency doctor as she was concerned about my breathing." Another person said, "They have alerted us to any rashes or things that might need a doctor to have a look. It's helped nip things in the bud."

Where a need had been identified people were supported to maintain a balanced diet. Staff helped by preparing meals, snacks and taking some people shopping. Specific dietary requirements were clearly noted in care plans, for example difficulties with swallowing and the need for thickened fluids and a soft diet.

Good

Is the service caring?

Our findings

The majority of people we spoke said they were very happy with their care. People told us, "I can't fault the carers they do everything I ask" , "They are lovely carers, nothing is too much trouble for them" and "It helps to lift me from being down and they are lovely lasses. I look forward to them coming round." Some comments were slightly more negative, such as, "My general impression is mostly very good. Some are a bit less caring" and "I would still recommend them they are good enough, not bad but could be better."

Family members told us they were happy with the care their relatives received. One family member we spoke with told us, "I am very happy with the caring attitude of the staff. They treat my husband very well and they are very respectful towards me at all times, some of them have become such good friends." Another relative told us, "They are polite, respectful and very nice. The carers are nice people."

People we spoke with told us that staff respected their dignity. One person said, "When I am getting ready I am always treated with the utmost respect." Another person told us, "[staff member] is very discreet and considerate." Family members also told us that staff respected peoples' privacy and dignity. One relative told us, "They definitely respect [person's name]'s dignity, they close the blinds and use towels to cover them when washing and dressing."

Staff we spoke with knew the people they cared for well and told us how they supported people with privacy, dignity and kept confidentiality in mind. One staff member told us, "I always shut the curtains to ensure people have privacy and I will leave people to do what they can on their own before giving any extra support." Another staff member said, "I always make sure I leave their care plan in a secure place."

Staff told us that they would promote people's independence wherever possible. One member of staff said "I ask what they would like me to do. Some people can put their own jewellery on but need help with their clothes." Another member of staff said "It's about being able to keep the service users as independent as possible, to support and assist them." People confirmed that staff encouraged them to be independent. One person said, "I've had no accidents and they respect my independence… they let me do things myself but they will be there."

Staff spoke very positively about their work. One staff member told us, "A lot of the people are lonely and just want to talk." Another told us, "I enjoy doing what I do. It makes me feel nice to help other people."

The comments people made indicated that staff took time to talk with them and built good relationships rather than being completely task focussed. For example one person said, "I am very happy with all the care I receive, I chat and joke with the girls." Another said, "The staff chatter to me all the time."

The registered manager told us that the service did have access to advocacy services but that they had not had reason to use them.

The service provided end of life care alongside NHS Continuing Healthcare and staff had received end of life

training.

Requires Improvement

Is the service responsive?

Our findings

People we spoke with said they were involved in making decisions about their care and support. One person we spoke with said, "I am involved with the reviewing of my care on a regular basis, usually every three months." We saw evidence on care files of telephone reviews taking place approximately every two months, and saw that care plans were signed by the people receiving care.

We saw evidence that the reviews being undertaken had a positive impact on people's experience. The service had responded to requests from people using the service and this was reflected in the comments people made. One person told us, "[The service] have done reviews quite regularly. Yes, they are trying to get it better…I am confident they will try to do their best. They are taking us seriously." Another example of how the service responded to feedback came from one person who told us, "I get on with all of [the care staff] except one – they don't send her now."

Staff confirmed what people had told us about their involvement. One staff member said, "I think people are involved. If they are wanting something changed I will encourage people to speak to their social worker and see what we can do." Another staff member said, "If any changes are highlighted by the service user I would pass this on to be reviewed."

The care plans we looked at were not all written using the same templates. The registered manager explained that new documentation had been introduced and not all of the care files had yet been transferred over to new paperwork. There was a noticeable difference between the two styles with one document containing much more detail and the other being more 'tick box' style. When we spoke to the registered manager about this we were told that the more detailed forms were the older style that were being phased out. We talked about the need for care plans to contain more detail in order to be suitably person centred. In particular we discussed the fact that the new care plans were even more lacking in detail and the registered manager was going to look at ways of addressing this.

Social calls were made to a number of people to provide company, social interaction and where appropriate take people out into the local community. Where these calls were part of the care package more information was needed in care plans to inform staff of the type of things people enjoyed doing during this time. One care plan we looked at said, "[person's name] likes to go out sometimes. If [person's name] stays in then it is the responsibility of the carer to ensure [person's name] is given a choice of what they would like to do." There was no information included in the plan to indicate where the person liked to go when out or what activities they enjoyed if they stayed at home.

Where changes had been made, for example to calls times, the old documentation had been left on file making it difficult to see at a glance which was the most up to date information.

Staff told us that they referred to people's care plans to establish their support needs and preferences. All of the staff we spoke with said that they understood the care plans. One staff member said, "When I go to visit a person for the first time I always look at the care plan, I find them easy to follow." Whilst this demonstrated

that good practice was being adopted by staff, the lack of detail within the care plans meant that they did not have access to all relevant information.
We recommend that the provider refers to best practice guidance in respect of person centred care planning.

We asked staff how people were offered choice. One member of staff told us, "I always offer people choice. If I'm doing lunch for example I will ask what they like, show them what they could have and try to offer a number of choices." Another staff member told us, "I try to offer a number of alternatives."

The times of calls had been a problem for some people using the service and this was something that the registered manager and the director recognised as an ongoing issue. At the time of our inspection the service were looking at different ways of addressing this in conjunction with the local authority commissioning team. Travel times between calls could sometimes cause problems for staff and the registered manager told us they tried where possible to address this. One member of staff we spoke with told us, "travelling time can be a problem but where a problem has been identified the coordinators have done what they can."

The service had a complaints policy in place and everyone we spoke with was confident they knew how to make a complaint if necessary. People told us, "If I needed to complain I would ring the office" and "I did complain once and was pleased with the outcome."

A number of complaints had been received so far this year, these were held in two different files depending on the nature of the complaint and this made oversight of all complaints more difficult but there was approximately 11 in total. These included things such as change of call time and confidentiality. We could see that the complaints had been investigated fully however the space on the forms that asked whether the matter had been resolved to the customer's satisfaction was left blank and it was therefore not possible to gauge whether there had been satisfactory outcomes to complaints.

Good

Is the service well-led?

Our findings

People we spoke with had not had contact with the registered manager but did not see this as a problem. One person said, "I have never spoken to the manager in the office." Another person told us, "If I need to contact the office I speak to [staff member] and she is always helpful.

The main complaint that people made during our inspection was about the difficulties they had contacting the service. Five out of the 27 people we spoke with had experienced problems and comments made included:

"I have no problem with the carers, it is the lack of communication that's the problem"

"The office staff are helpful, the problem is getting through to them. No one answers the phone and you leave a message but they don't get back to you"

"I would like to see communication improve."

"Messages don't get passed on."

A relative told us, "my husband has good carers but it is very difficult to get hold of the staff in the office, I have to ring several times before I get through."

This problem was also reflected in the results of the client's survey in 2015 when fifteen people had indicated that they had problems contacting the office by telephone. A meeting was held on 6 April 2015 to address the findings of the survey and it was noted in the minutes that 'do not disturb' facilities must not be used on the office telephone, however, the comments made to us during our inspection would indicate that this is still an on going problem. We discussed this with the registered manager and they explained that all calls are now recorded and it was possible to track whether or not calls had been returned. An email audit trail is also being adopted as a way of tracking any voicemail messages and returned calls. Whilst this issue is evidently on going steps have been taken by management to address this. We passed some of the comments we had received on to the registered manager during our visit and as a result the problem was going to be investigated further.

Staff told us they felt that the management team were very supportive. One member of staff told us, "[registered manager] is the best manager I have ever worked under, you can talk to her and she really listens." Another said, "I feel well supported and that gives me the chance to go and give the service users more support."

The registered manager told us that customer surveys were completed by people using the service every six months. We saw evidence of this and looked at the responses received from the most recent survey. Staff surveys were also conducted annually but the response rate to these was not high and the registered manager and director spoke about this and looking at ways to encourage greater participation in this form

of feedback.

We were told that team meetings were held regularly and saw evidence of this. Minutes showed that these meetings were held approximately every two months. Topics discussed at these meetings included changes to the rota, mobile phones, sickness absence, cold weather and new staff. The staff we spoke with told us they found these meetings useful. One staff member told us, "Staff meetings are always productive. Working in domiciliary care you work solo most of the time so it is good to bounce ideas and concerns off each other." This showed us that although staff were not always responding to surveys they were involved and their opinions were sought in other ways.

The director told us, "We try our hardest to keep morale up." We saw that the service held staff award ceremonies where staff who had been nominated by people using the service were recognised for their hard work. Awards included a new starter award and shining star award. The service also appointed a medicines champion of the year. Staff we spoke with did all seem positive about the service and their role. One member of staff told us, "I'm really happy in my work, I love my job and I love working for the company."

The registered manager showed us a copy of the monthly newsletter they produced and circulated to people using the service and staff. This included news about the staff awards ceremony, Christmas hampers being delivered to people by the registered provider and the introduction of a bingo and games afternoon at a local community centre. We also saw a staff newsletter that included information about flu jabs, confidentiality and bogus callers. This showed that the registered manager was using alternative forms of communication to keep in touch with people using the service and for those staff who may not be able to attend staff meetings.

The staff we spoke with felt that there was an open culture within the home that the team worked well together. A member of staff told us, "I love it. The support I get and the good team spirit. You get praise and recognition and support when you need it." Another said, "I find it an open culture. There is always somebody to go to and you always know who to go to." Staff also told us they felt that any problems would be taken seriously, "If I have any concerns I can come in and I know they will do the appropriate thing."

The registered manager undertook regular audits of the service and created action plans where necessary. Care plans were audited monthly and approximately 20-30 records were looked at every month. These were tracked on a computer system that flagged up which care plans were due to be audited. Any issues found were highlighted as action points on the file and these were to be implemented by staff and followed up by management. This meant that the registered manager was regularly checking on the quality of the service.

The service had introduced a dedicated team of medication champions who had developed community links with local GP practices and pharmacists to ensure that care teams received up to date and accurate information around best practice. This team was managed by a medication quality assurance manager and we were told that the number of incidents and errors relating to medicines had been reduced since its introduction.

The registered provider had also introduced a number of new posts that gave some staff greater responsibility and also gave staff a clear point of contact for things such as training, human resources and medication. A senior role had been introduced for a trial period to look at operational challenges such as sickness absence. We were told that the person who had been appointed to the senior role was greatly respected by other staff and they had seen a reduction in the level of sickness since the beginning of the trial. We were told that the plan going forward was to give key staff responsibility for things such as rotas, spot checks and supervisions. One member of staff told us, "I love what I do. They push me to go further and

I'm learning something new every day, I love it."

The registered manager had correctly submitted notifications to the Care Quality Commission. The registered provider is legally obliged to send us notifications of certain incidents, events or changes that happen to the service within a required timescale to enable us to monitor any trends or concerns.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment People who used the service and others were not protected against risks to their health and safety caused by incomplete assessment and mitigation of risk.