We Care Solutions Manchester Limited

We Care Solutions Chorlton

Inspection report

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Date of inspection visit:
14 February 2018
15 February 2018
19 February 2018

Date of publication:
17 May 2018

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 14, 15 and 19 February and was announced. We gave the registered manager one day's notice of the inspection.

We previously inspected this service in December 2016 when it was registered as 'Chorlton' with the Care Quality Commission (CQC). At that inspection we had discussed with the provider changing the registered name to reflect what the service is usually called. At this inspection we saw that the provider had changed the registered name to We Care Solutions Chorlton.

At our last inspection we found breaches of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when, to improve to at least good in the following areas : assessing the needs and preferences of service users; the need for consent; operating effective systems to assess, monitor and improve the quality of the service and ensuring that fit and proper persons were employed.

The service is a domiciliary care agency providing care and support to people living in their own homes. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults. Their office is in Chorlton in south west Manchester. At the date of this inspection they had approximately 65 people using the service in the Chorlton and Wythenshawe areas of Manchester.

Not everyone using We Care Solutions receives 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 our 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.'

Scheduled visits had been placed into 'runs' for care workers, mainly based on geographical location and individual need. The allocation of runs had contributed hugely in streamlining the service.

The service had introduced technology to assist with call monitoring. Monitoring logs reflected most staff were logging in and out and staying for the full duration of the call but some staff were not. Checks were not being done in real time following any unlogged calls and this meant the provider could not be assured that the call had taken place. During our inspection the provider put mechanisms in place to follow up on any unlogged calls once these were alerted on the system.

People were happy with the support they received with their medicines. If prescribed medicines were contained in blister packs then staff were able to administer, as per company policy. Not all MAR's were accurately completed and the service had identified this during monthly audits and addressed this with staff. .

At our previous inspection we identified issues around the timing and allocation of people's care visits and the high number of care workers allocated to individuals. At this inspection we saw that improvements had been made in all of these aspects and the feedback we received from people confirmed this.

Care workers were vigilant in terms of identifying and reporting any concerns they had regarding the people they supported. Following a safeguarding referral and subsequent investigation in 2017 the service had taken appropriate action in dealing with staff. The service was taking the necessary action to report and act on safeguarding concerns.

Care workers received a thorough induction, were well trained for the role and employees new to adult social care were signed up to the Care Certificate. Staff received spot checks from senior care workers to assess their performance and competence in their roles. Supervision sessions were recorded formally and care workers we spoke with appreciated supervisions and saw them as an opportunity to raise any concerns or discuss how they were feeling with a supervisor.

The provider had visited all clients in October and November 2017 to gauge people's capacity in relation to their care. Staff had received training on the mental capacity act and could give examples of how they obtained consent from people prior to assisting them with personal care. The service was now acting in accordance with the Mental Capacity Act 2005 and meeting the regulation.

Staff understood the needs of the individuals they supported. staff were polite, kind and respectful. Everyone we spoke with confirmed that staff always stayed for the allocated time and if commissioned duties were finished staff would find usually something else that needed doing.

Care workers respected people's privacy and dignity and gave us examples of how they did this. Staff also recognised the importance of encouraging people to be independent and how this benefitted the people they supported.

The service was exploring new ways of working, including an increased use of technology whilst ensuring confidentiality in relation to people's personal information was maintained.

People had been very much involved in writing their plan, alongside the assessor as care plans were person centred and written from the 'I' perspective. People had received an initial assessment where they were asked what support they required and what their preferences were.

People felt confident they could change their care plans if they wanted to. People were involved in planning and individualising their own care and confirmed that they could change this as the service was flexible in their approach.

The service regarded complaints as an opportunity to learn and improve. The service investigated and resolved formal complaints in a timely manner and acted upon informal feedback to resolve problems.

The rating from the previous inspection was clearly displayed in the office. Prior to our site visit we checked the provider's website to see if the current rating of the service was displayed and it was not. Failure to

display the current rating of the service on the company's website is a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Systems to monitor and assess the overall quality of its care provision had improved. Audits had identified the improvements needed and these were addressed with staff.

There was a formal system for seeking feedback on the service they provided from people and their families. Where feedback was not positive the service acted accordingly and acknowledged the feedback. The service responded positively to criticism and looked to make improvements to provide a better quality service.

The provider was proactive in working in partnership with the local authority and implementing new processes and procedures in order to improve the service. The Chorlton office was well staffed and was using modern technology to improve the quality of the service.

You can see what action we told the provider to take at the back of the full version of the 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.

The service had introduced technology to assist with call monitoring but checks were not being done in real time following any unlogged calls.

Scheduled visits had now been placed into 'runs' for care workers and this had helped to streamline the service.

People were supported by consistent staff. Issues around the timing and allocation of people's care visits had been resolved.

Is the service effective?

Good

The service was effective.

The provider's approach to assessments had improved. People received care and support according to their preferences and wishes.

The service was proactive with regards to the assessment of capacity for specific decisions relating to the provision of care. It was working in accordance with the Mental Capacity Act 2005.

Care workers received spot checks to assess their performance and competence. Supervision sessions were recorded formally and were valued by care workers.

Is the service caring?

Good

The service was caring.

Staff understood the needs of the individuals they supported. staff were polite, kind and respectful.

Care workers respected people's privacy and dignity and gave us examples of how they did this.

The service was exploring new ways of working, including an increased use of technology, whilst ensuring confidentiality in

relation to people's personal information was maintained.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care plans in the office were person-centred and individualised to people's needs. Not all care plans in people's homes accurately reflected the person's needs.

People had been very much involved in writing their plan. Care plans were person centred and written from the 'I' perspective

People were involved in planning and individualising their own care. They could change this as the service was flexible in their approach.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Systems to monitor and assess the overall quality of its care provision had improved. Audits had identified the improvements needed in relation to recording the administration of medicines.

The rating from the previous inspection was clearly displayed in the office but was not displayed on the website at the time of our inspection.

There was a formal system for seeking feedback on the service they provided from people and their families.

The provider was proactive in working in partnership with the local authority and implementing new processes and procedures in order to improve the service.

We Care Solutions Chorlton

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.

Inspection site visit activity started on 14 February and ended on 19 February 2018. We telephoned the registered manager one working day before the inspection so that we could be sure there would be someone at the office when we arrived. We visited the office location on 14 and 15 February to see the manager and office staff and to review care records and policies and procedures. On the third day of inspection we made visits to three people in their own homes with their permission.

The inspection team consisted of two adult social care inspectors on the first day of inspection and one adult social care inspector on the second day, who both visited the home care agency's premises. Two experts by experience contacted people in their own homes or spoke with relatives on the telephone, to obtain their views on the service. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. An adult social care inspector spent a third day visiting people in their own homes with their permission. This was to observe aspects of care, for example meal preparation, medicines and interactions with staff.

As part of the inspection we reviewed the information we held about the service. This included contacting the Manchester Council safeguarding team, commissioners of care and speaking with an officer from the Quality and Contracts team in Manchester. The commissioners were able to confirm that safeguarding referrals had been made to them by the service and a contracts officer had undertaken a monitoring visit in September 2017

During our inspection we spoke with the registered manager, the nominated individual, and four care workers. We spent the first and second day of the inspection at the service's registered address speaking with staff and looking at records. These included seven people's care records, four staff recruitment files, staff training and supervision records, policies and procedures and other documents relating to the management of the service. On the third day of inspection we visited three people who used the service in

their own homes and spoke with two of their relatives; this included looking at people's care documents with their permission. After the inspection we telephoned 12 more people at home and five other relatives and spoke with five staff over the telephone.

Requires Improvement

Is the service safe?

Our findings

We asked people if they felt safe when they used the service and they said that they did. One person told us, "They [staff] let themselves in and I recognise their voices. They always put the key back so I know I'm safe." Another person we spoke with needed equipment to help them move and they told us they felt safe with staff who used this and told us, "Yes, I've never felt at risk. They always do [hoist] transfers safely, for example." Relatives also told us they thought their family members who used the service were safe and one relative told us, "Oh yes, I always feel that [person] is safe. The carers are very good."

The service had introduced technology to assist with call monitoring that staff were to access for a scheduled call. Staff were expected to log in on arrival and log out on leaving, using personal mobile phones to access an application which logged that a call had taken place. We saw monitoring logs which reflected staff were logging in and out and staying for the full duration of the call. Some staff had not logged in or out for every call though so the service had devised a daily log to record these occasions, however this log was only produced the following day.

The provider gave us examples when staff might not log in and out of calls, for example staff had run out of mobile phone data or could not get a signal. We could not see what action was being done by the provider to verify that these calls were not missed calls and brought this to the manager's attention. On our first day of inspection a relative contacted the office and alerted them to a missed visit earlier that day. As no real time checks were done following any unlogged calls this meant the provider could not be assured that the call had taken place, therefore people were potentially at risk. Following our discussion and the missed call the provider immediately put mechanisms in place to follow up on any unlogged calls once these were alerted on the system.

Some of the people using the service were supported with their medicines. We looked at the printed medicines administration charts (MARs) care workers used to record medicines. These charts were a template produced by the service.

All of the people we spoke with who were supported to take their medicines told us they were happy with the care they received. If prescribed medicines were contained in blister packs then staff were able to administer, as per company policy. We reviewed medication charts that had been returned to the office and identified that not all MAR's were accurately completed and saw gaps in the recordings. Where we identified gaps we checked the daily notes and saw that staff were noting medicines had been given in the log book but not always on the MAR chart. Audits completed by the service had picked up these recording issues and we saw this had been addressed with staff in a meeting held on 25 January 2018. The nominated individual told us that now visits were more organised these errors were less frequent. We checked the MAR's for the people we visited in their own homes and found these to be accurate. We will review this at our next inspection.

Care plans stored in the office and those in people's homes contained appropriate risk assessments We saw examples of generic risk assessments in relation to the environment and infection control but also more

person-centred risk assessments based on individual need in relation to medicines and moving and handling. Staff we spoke with were aware of the risks posed to people and told us of the steps they would take to minimise risks. For example if using equipment to move people they would make sure lap belts were used on wheelchairs and slings on hoists used correctly.

People using the service were supported by care workers who visited their homes during a set window of time for an agreed duration. At our previous inspection we identified issues around the timing and allocation of people's care visits and the high number of care workers allocated to individuals. At this inspection we saw that improvements had been made in all of these aspects and the feedback we received from people confirmed this. One relative we spoke with told us, "Consistency is important to my [relative] because he has certain mental health issues. So it's good that we have the same carers."

The nominated individual showed us that scheduled visits had now been placed into 'runs' for care workers, mainly based on geographical location and individual need. For example some runs consisted of two care workers as people were more dependent and required assistance with mobilising, moving or repositioning. Other runs required one care worker providing assistance as people were more independent and able to do some tasks for themselves.

The allocation of runs had contributed hugely in streamlining the service, as calls were mapped out and more manageable, either for individual care workers or for two care workers, undertaking those visits where people needed a higher level of assistance. The provider could evidence via the technology in use that people were receiving calls on time and staff were staying for the duration of the commissioned call. There were enough staff to enable all visits to people were done within acceptable timeframes. On the occasions that staff were delayed and late for a call people told us they were notified of this. One person said, "They're reasonably on time but if they're running late someone will always ring and let me know," and another person added, "They're not late very often [but] somebody from the office rings to let you know."

At our previous inspection we identified that the service was not undertaking timely checks to ensure fit and proper persons were employed. We checked the service's recruitment procedures to see if improvements had been made and found that they had. We looked at the recruitment records for four care workers and found that all had a Disclosure and Barring Service (DBS) check prior to starting employment. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. The personnel files we looked contained the original application form, two written references and copies of photographic ID. We saw that if a DBS for a prospective member of staff was not clear the provider had a risk assessment process in place to ensure the potential employee was suitable to care for vulnerable adults, which is good practice. This had been introduced following a monitoring visit from the local authority who had identified this as a area for improvement.

We asked the care workers we spoke with to describe the forms of abuse people using the service might be vulnerable to and they could. Care workers also said they would report any suspicions of abuse to their managers. One care worker told us, "I would report anything not right straight away." We saw in records at the service that care workers did report concerns they had about the people they supported to the senior care workers. This meant that care workers were vigilant in terms of identifying and reporting any concerns they had regarding the people they supported.

We saw that following a safeguarding referral and subsequent investigation in 2017 the service had taken appropriate action in dealing with staff. We identified that the service did not have a copy of the local authority's multi disciplinary safeguarding procedures and brought this to the registered manager's attention. We were assured however, that the service was taking the necessary action to report and act on

safeguarding concerns.

Some of the people using the service received assistance from care workers with their personal care, for example, with washing and dressing and continence care. We asked people and their relatives if care workers always washed their hands and used personal protective equipment, such as gloves and aprons, when assisting with personal care. All of the people we spoke with spoke highly of staff in relation to maintaining good hygiene. One person told us , "They always wear gloves when they're giving me a shower or changing my bed", whilst another said, "They [care workers] are always hygienic; they wear gloves and aprons." We were assured that people were kept safe from the risk of the spread of infection due to good staff practices, including the use of personal protective equipment.

Good

Is the service effective?

Our findings

We asked the people and their relatives if they thought the care workers who supported them were well trained. People told us, "Yes, they're very good and if they're new and not very sure, they soon pick it up quite easily; they're always sent with someone who knows me" ; and "Yes, they're always very, very good."

As part of this inspection, we looked at the care files of seven people who used the service at the office and three other care files in the homes of the people we visited, after obtaining their permission. At our last inspection in December 2016 we identified that the assessment of peoples' needs was not detailed enough prior to someone receiving a service from We Care Solutions Chorlton. We saw at this inspection the approach to assessments had improved and people we spoke with confirmed they received care and support according to their preferences and wishes.

The care workers we spoke with told us that they had received training to undertake their roles. We checked the training records of four care workers and received a copy of the company's training matrix, which outlined the dates all staff had completed mandatory and other training. The service had a large basement room on site which had been converted into a meeting room and this doubled as space for training. Induction training was undertaken in this environment which also had enough space to enable staff to practice and perform moving and handling techniques.

We saw that the service used the Care Certificate for employees joining the service who were new to adult social care. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. The service was also accessing appropriate training courses run by the local authority, for example safeguarding adults, as well as accessing training from other external sources and completing workbooks. Staff were able to choose topics they felt they needed additional training in or had a particular interest in, for example such as medicines, dementia and dignity. Staff we spoke with told us they felt fully prepared for the role of care worker and one member of staff said, " They [senior staff] tell me if there's any problem, or you're not 100% sure, tell the office and you can have the training again. I feel I have all the skills I need now, but for the future I'd like more and I have the chance to do more training. I find it interesting."

Care workers told us and records we saw confirmed that they received spot checks from senior care workers to assess their performance and competence in their roles. These spot checks took place in people's homes during care visits where care workers were assessed in terms of how they interacted with the person, whether they encouraged people's independence, whether they offered choices to the person and on their appearance. Records we saw supported these checks took place and if any issues were identified these were addressed with staff at the time or in staff meetings.
Supervision sessions were recorded formally and records we saw reflected this. Supervision provides the manager or supervisor with the means to communicate with an employee and inform them of the standards of performance which the organisation expects. It can also help facilitate a formal discussion about the employee's actual performance and gives the staff member the opportunity to raise concerns or ask questions.

Care workers we spoke with appreciated supervisions and saw them as an opportunity to raise any concerns or discuss how they were feeling with a supervisor. One staff member told us, "Everybody has training and carers can go to management any time to talk about how we are managing, our feelings, training needs, desire to go further etc. We do have set supervision as well." During our inspection we saw that the service also encouraged care workers to come into the office to talk informally if they needed support or had problems. Our discussions with care workers showed that they liked the approach to spot checks and supervision and felt comfortable in raising any concerns with their managers.

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 make particular decisions any made on their behalf must be in their best interests and as least restrictive as possible.

We saw that the provider had visited all clients in October and November 2017 to gauge people's capacity in relation to their care. People were asked if they understood their care needs and the service checked if people knew what medicines they were taking and why. They also checked if people knew how to complain and who to contact in an emergency. This assessment formed part of their care plan that care workers could consult. It demonstrated that the service was proactive with regards to the assessment of capacity for specific decisions relating to the provision of care.

We asked staff if they had received training on the Mental Capacity Act; most said they had and all could give examples of how they obtained consent from people prior to assisting them with personal care. We saw that the Mental Capacity Act was an element of training incorporated in to the company's induction pack and care workers we spoke with were aware of best interest decisions made on behalf of people who could not consent to care. Staff recognised and respected that people had the right to makes choices but told us they would seek further advice and guidance from management if they felt decisions were unwise or placed the person at risk.
The service was now acting in accordance with the Mental Capacity Act 2005 and meeting this regulation.

Some of the people we spoke with were supported with food shopping and meal preparation. Each person said that they were happy with the support they received and the meal choices care workers provided them with. People told us, "I have meals on wheels sometimes, and [the carers] put them in the microwave for me. They get me my breakfast – cereal, whatever I want, and make me a cup of tea",and "I choose from [a selection of meals bought in by family member, in agreement] and the carers warm it up for me." This meant that people were given choices of meals that were prepared to their liking.

We asked people if care workers helped them to book appointments to see other healthcare professionals, such as GPs or district nurses. Most said they managed this themselves or were assisted by a family member.

People we spoke with told us care workers would help with making or attending health appointments if needed, and were sure they would call a doctor if necessary. One person we spoke with told us, "They have given me advice, for example they've suggested I should get a doctor to see me when I've not been well." A relative we spoke with told us a senior member of staff had responded quickly and called an ambulance for their family member. People and their relatives also told us the care worker or someone from the office would contact them and mention if medicines were running low. We were assured that people were supported to maintain their holistic health when they either asked for it or the service recognised this was needed.

Good

Is the service caring?

Our findings

Some of the visits we made to people's homes were timed to correspond with visits made by care staff. We observed the carer undertaking duties with warmth and care, whilst also maintaining a professional approach. The mood in the person's home was relaxed and friendly and the carer had established a good rapport, not only with the person they were supporting, but also with other family members who were present. We asked people and their relatives if they thought the care workers who supported them were caring. The responses we received were positive. People told us, "Yes, they're all lovely people and all very good" and "They're trustworthy."

We spoke with a relative who told us that staff interacted with their family member even though they weren't able to answer verbally. They described to us how one member of staff sang a song their relative liked and told us, "It makes me happy to see [person] smiling." This demonstrated to us that staff were caring and respectful and treated people as individuals.

One of our visits to a person's home coincided with a care worker providing lunch time support. English was not the individual's first language, however we noted that the care worker was able to communicate with the person in their native language. A family member we spoke with was very complimentary of the core team of care workers who supported their relative. Whilst not all care workers could communicate fluently in the person's native language it did 'help a lot' when one could.

From the conversations we had with staff it was evident that they understood the needs of the individuals they supported. We saw and were told that staff were polite, kind and respectful. Everyone we spoke with confirmed that staff always stayed for the allocated time and if commissioned duties were finished, staff would find usually something else that needed doing. People told us, "They [care workers] always ask if there's anything else I want, or anything different" and "They will will go above and beyond to get you things you need."

As part of the inspection we wanted to find out whether care workers respected people's privacy and dignity and knew them well as individuals. All of the care workers we spoke with could describe the people they supported regularly, including their likes, dislikes, preferences and the way they asked to be supported. They also gave us examples of how they promoted people's privacy and dignity.

One care worker said, "When I'm dressing or undressing someone, getting them washed etc, I make sure the doors and curtains are closed; you cover private areas, ask family members to leave the room; things like that." All of the people we spoke with when asked agreed that care workers respected their privacy and dignity and one person told us, "There's no need for anything in particular [because of the arrangement of the home] but they're always very respectful and I never feel exposed."

Care workers told us how important and beneficial it was to help promote people's independence so that they could stay in their own homes for as long as possible. One care worker told us, "It's important to let people do as much as they can. It makes them feel good." The people we spoke with agreed that care

workers always gave them choices when supporting them. One person told us, "They never take over, no", whilst another person said, "I am very limited in what I can do, but where possible, they make things as handy for me as they can." This showed that care workers tried to promote people's independence by encouraging them to do things themselves and by providing choices.

We visited the office of We Care Solutions – Chorlton as part of our inspection. We found that both electronic and paper documentation was stored securely. The service was exploring new ways of working, including an increased use of technology whilst ensuring confidentiality in relation to people's personal information was maintained.

Whilst no one currently receiving a service had an advocate in place the registered manager was aware of services available should this be required. We saw instances where the provider had notified the local authority and other health professionals if they had specific concerns about a person, or if they felt they warranted additional support.

Requires Improvement

Is the service responsive?

Our findings

Care plans included the support people needed with daily aspects of living, such as bathing, dressing or meal preparation and provided care workers with detail in terms of any moving and handling that was required. Each person had a front sheet which listed their next of kin details and information about the other healthcare professionals involved in their care.

We saw that people had signed a consent to receive care and this was in the front of files. People had been very much involved in writing their plan, alongside the assessor as care plans were person centred and written from the 'I' perspective. Care plans were broken down into three sections under headings such as, 'what I need support with'; 'how I will be supported' and 'agreed goals and outcomes'. This last aspect in relation to identifying outcomes for people is in line with the Care Act 2014 and is recognised as good practice as providing a quality service is not just about meeting an individual's care needs.

Care plans we saw in the office were person-centred and individualised to people's needs, containing details of the support they needed and the order in which they preferred to receive that support. Care preferences were outlined according to visits undertaken during the day, for example at breakfast, lunch, tea and bed, depending on the frequency of support an individual received. We saw that these were personalised for individuals and included details about how people preferred hot drinks and the environment. For example, one task list we saw detailed that the bed was to be neat and tidy, the person liked tea with two sugars and a little milk and that care workers were to make sure the person had access to lots of liquids before leaving after the morning call.

Not all care plans we saw in people's homes contained all the information appropriate to the individual. For example, one person we visited was a diabetic. This was recorded on file but was not detailed in their eating and drinking care plan. A relative we spoke with did say this was not a problem as the family made all the meals available and that the existing staff team knew their family member well and were aware of the risks in not providing the correct diet. Similarly this care plan did not refer to the person's native language. The care worker we saw preparing a meal was able to communicate with the person in their native language, so again was aware that this was important to the individual. On this occasion we were not reassured that this person would always receive the care they preferred as the information care workers had access to was not detailed enough.

We recommend that all care plans accurately reflect people's needs as identified at assessment. A care plan should contain all information relevant to that person so that all care workers can provide appropriate care.

Areas covered within care plans included aspects of daily living, choice and control; keeping safe; managing my actions safely and a section on advanced planning, although these were not always completed on the care plans we looked at. Care plans also contained a premises risk assessment, a medicines risk assessment, which indicated if the person had the mental capacity to manage their own medicines, as well as a moving and handling risk assessment which detailed any equipment used to aid with mobility.

We asked people how they were involved in planning the care and support they received. People we spoke with said that they had received an initial assessment where they were asked what support they required and what their preferences were. One person said, "My [relative] and I did it when I first started. [Manager's name] came round and asked me what was required."

People we spoke with they felt confident they could change their care plans if they wanted to and that they were reviewed regularly, including during spot checks on staff. One person we visited told us that prior to Christmas they had received an earlier morning call. As they preferred to stay in bed in the morning they had requested a later call and we saw that this was now being done at 11am. They were happy that they received support at the time they had asked for and told us altering the times of support had been easy. Similarly if people wanted to change the times of their support, to accommodate an appointment for example, the service tried to be as flexible as possible. One person told us, "Yes [the service is flexible]. Sometimes if I have an appointment somewhere, I ask the office if the carers can come, say 15 minutes early. They'll do everything they can to help." This meant that people were involved in planning and individualising their own care and confirmed that they could change this as the service was flexible in their approach.

We asked care workers how they made sure they supported people appropriately and ensured that they received the care they wanted. The care workers we spoke with all told us that they would read the person's care plans upon arrival. Staff we spoke with recognised the importance of the care plan. One care worker said, "With a new client, there's an initial assessment, and that gives an idea of a person's capacity and understanding of why we are there [as carers]. It's all put in the care plan."

We looked at the daily records of five people who used the service. Daily records are completed by care workers at the end of each visit; they should describe the support the person received and make reference to people's care plans in order to evidence that people have received the support they asked for. We asked people if care workers read their care plan and delivered care accordingly and one person we spoke with said, "'Oh yes, and I'm able to tell them the order of things I need doing in a particular way."

We looked at how the service handled and dealt with complaints raised by people using the service or their representatives. The service regarded complaints as an opportunity to learn and improve. We saw examples of when they had responded positively to complaints, contacting a complainant in person or by letter, and within stipulated timescales. One complaint made by a relative was that their family member was not being given the opportunity to shower regularly enough. We saw it noted on the complaints record that the relative was apologised to in person and reassured that care workers would ask daily if the person required a shower, and this was noted in communication logs. No further complaints had been made by the family. This meant that the service investigated and resolved formal complaints in a timely manner and acted upon informal feedback to resolve problems.

Some people did describe occasions when they had provided an informal concern or feedback to the service about things they were not happy about and told us that these had been resolved once management were made aware.

Requires Improvement

Is the service well-led?

Our findings

We saw that the rating from the previous inspection was clearly displayed in the office on our arrival to carry out the inspection. Prior to our site visit we checked the provider's website to see if the current rating of the service was displayed. We noted it was not. We discussed this breach in regulation with the registered manager and nominated individual and this was addressed.

Failure to display the current rating of the service on the company's website was a breach of Regulation 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked people and their relatives if they thought that We Care Solutions was well managed and people told us it was. , "There's always a few there; out-of-hours too. They're very polite and helpful", and, "I mostly speak to the manager. They do their best to sort things out for you." We also asked the staff what they thought of the managers; they told us they were approachable, supportive and easy to talk to. Staff we spoke with enjoyed working for the company.

The management of the company understood their roles and responsibilities. The registered manager was fully supported by the nominated individual, who had a hands on role in the company and was a daily presence in the office.

As part of the inspection we asked the registered manager and nominated individual how the service was audited for safety and quality. We saw that documentation in relation to care, for example medicines records and log books, were collected from people's homes on a monthly basis for audit and archiving purposes. Spot checks were carried out by the service and we saw documented evidence of spot checks that had been carried out by the registered manager. People we spoke with were aware of these checks and told us, "Some one comes every few months to check on the carers." They considered it a good thing that care workers were checked on.

Aspects evaluated during spot checks included noting whether carers were referring to support plans, if medicines were administered correctly, whether the carers treated the person with dignity and respect and if uniforms and identity badges were worn by staff. The spot check form also included observations from service users. People were asked their opinions in relation to staff following the care plan and if they were happy with the staff currently supporting them.

At the previous inspections in November 2016, we found the service had not implemented effective systems to monitor and assess the overall quality of its care provision. At this inspection we checked to see what systems had been put in place. The nominated individual demonstrated the current software in use, the OneTouch system, indicating how care workers logged in and out of calls using a mobile phone. As this system worked with real-time data, gaps were flagged up, for example when staff did not log in and out of a call. We saw that the day prior to our inspection the service had identified 13 unconfirmed visits. Prior to this inspection these gaps were not being explored proactively and the registered manager could not be assured these visits had taken place. Following discussions with the nominated individual the provider put

mechanisms in place to explore the alerts immediately and any care workers not able to log in and out communicated by text to the office that visits had taken place.

The service audited log books and MARs on a monthly basis. These were removed from people's properties at the end of each month and replaced with new ones. We looked at audits of log books and MARs and found issues that had been identified by the registered manager, for example gaps in the recording of administered medicines. It was documented on two audit checklists that this was to be addressed in a staff meeting held on 25 January 2018 and we saw that the administering and accurate recording of medicines was an agenda item and had been discussed with all attendees.

We saw that two representatives from the local authority contracts and commissioning team had carried out a monitoring visit in September 2017 and were supplied with a copy of their report.
As a result of this visit a number of actions had been identified for the provider to address in order to achieve compliance. We saw the action plan and the progress made to date at the time of our inspection for example, in relation to care planning, recruitment and audits. This showed us the provider was proactive in working in partnership with the local authority and implementing new processes and procedures in order to improve the service.

The nominated individual demonstrated to us the new systems recently adopted by the service. They showed us that scheduled visits had now been put into 'runs' for care workers, mainly based on geographical location and individual need. For example some runs consisted of two care workers as people were more dependent and required assistance with mobilising, moving or repositioning. Other runs only required one care worker providing assistance as people were more independent and able to do some tasks for themselves. This had greatly helped to streamline the service and meant people received a consistent team of care workers.

The service had a system in place for the logging and follow up of any accidents or incidents. We checked the concerns raised by care workers relating to the safeguarding of people using the service and saw that the registered manager and nominated individual had taken appropriate action, interviewing staff, collecting statements and ensuring the person and / or family members were happy with any actions taken. This meant that the registered manager had oversight of all the incidents and accidents that occurred at the service and we saw examples that showed the correct action was taken.

The provider had implemented a formal system for seeking feedback on the service they provided from people and their families. We saw examples of people's responses from questionnaires distributed prior to this inspection and noted that the majority of comments were positive about aspects of the service. Comments from people on questionnaires included, "I am very happy with the service you provide"; "Thank you for the excellent care given" and "Service is good – satisfied. No concerns." One response from a person receiving a service in June 2017 considered the care to be good and scored it as a B but when asked how well the office did this was scored as a D. The provider had written acknowledging this feedback and outlined improvements that were scheduled. This showed us that the service responded positively to criticism and looked to make improvements to provide a better quality service.

We asked if staff meetings were held and were told that they were. Staff we spoke with and records we saw confirmed this. Due to the errors and gaps in recording on MARs medicines was an item for discussion on the agenda. We saw from these minutes that meetings were also used to deliver training. At a meeting held in September 2017 we saw that staff had been provided with a sample MAR, accurately completed and a photograph of a colour coded medicine blister pack, together with instructions on administering the blister pack. This showed us that the provider had identified weaknesses in staff practice and was trying to improve

in this area. We were assured that care staff received the support required to function effectively in their role.

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 will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 20A HSCA RA Regulations 2014 Requirement as to display of performance assessments On the day of inspection the rating from the previous inspection was not displayed on the website.