Genesis Recruitment Agency Limited

Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London

Inspection report

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Date of inspection visit:
22 October 2018
23 October 2018

Date of publication:
11 December 2018

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**

Is the service well-led?

Requires Improvement

Summary of findings

Overall summary

We undertook an announced inspection of Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London on 22 and 23 October 2018. We told the provider two days before our visit that we would be coming because the location provides a domiciliary care service for people in their own homes and staff might be out visiting people.

Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London is a domiciliary care agency that provides personal care to around 101 people in their own homes in the London Boroughs of Ealing and Brent.

We previously inspected Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London on 14 and 21 June 2018 and we found four breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to safe care and treatment, the need for consent, good governance of the service and staffing. The service was rated requires improvement in the key questions of safe, responsive, caring and effective with well-led rated inadequate. The service had an overall rating of requires improvement but remained in special measures. Prior to this the service was rated inadequate.

At the time of this inspection a registered manager was in post. The registered manager was also a company director. 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.

The provider had a medicines policy and procedures that were in the main followed, but the administration of medicines for some people were not being recorded accurately. The quality assurance processes for the management of medicines did not always identify when issues occurred so these could be rectified.

The provider had made improvement to their mental capacity assessment process but it still did not relate to the capacity of the person to make decisions in relation to a specific aspect of the care they received and their daily life. We have made a recommendation in relation to this.

Records relating to people using the service did not always provide accurate information relating to the care and support they needed. The provider told us about their plans to improve this. Other records identified how the person wanted their care provided including their likes and dislikes. People knew how to make a complaint and provider had followed their complaints procedure where complaints had been received.

The provider quality assurance processes were not always effective because they had not identified the shortfalls and areas for improvements we had identified so these could be put right.

Improvements had been made in relation to risk management plans with the levels of risk to people's safety

and wellbeing being reviewed and being based on the person's current health and care needs. The provider was also reviewing incidents and accidents so learning took place to prevent reoccurrence.

The provider had introduced a procedure to monitor the times of each visit and identify the reason why a visit had not occurred at the planned time. Care workers were allocated visits on their rotas with travel time and the visits did not overlap.

The provider had improved the assessment of staff competency in relation to moving and handling and medicines management to demonstrate that care workers were competent in these areas and had sufficient knowledge to perform these activities safely. Care workers had completed the Care Certificate and training identified as mandatory by the provider. They had a clear recruitment process in place.

We received mixed feedback from people about the care they received with some people telling us they were happy whilst other people identifying times when they were not happy.

People told us the care workers were kind and caring and treated them with dignity and respect when providing care. The care plans identified each person's cultural background, personal history and any religious beliefs.

People and care workers told us they felt the service was well-led.

We found two breaches of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches related to safe care and treatment of people using the service and good governance of the service.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

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

Some aspects of the service were not safe.

The provider had a medicines policy and procedures but medicines for some people were not being recorded accurately. The checks on the management of medicines did not always identify when issues occurred so these could be put right.

The provider had systems in place to protect people using the service. All care workers had completed safeguarding adults training.

Risk management plans were in place providing guidance for care staff on how to minimise risks for people using the service and the levels of risk had been reviewed.

The provider had introduced a procedure to monitor the times of each visit and identify the reason why a visit had not occurred at the planned time to make sure that people always receive their visits as planned. Our findings showed improvements in this area.

Is the service effective?

Requires Improvement

Some aspects of the service were not effective.

The provider had made improvement to their mental capacity assessment process but it still did not relate to the ability of the person to make decisions in relation to a specific aspect of the care they received and their daily life. We have made a recommendation in relation to this.

The care plans for each person identified their GP and any other healthcare professional that was involved in their care and the support they needed to meet their healthcare needs.

Care staff received the training and supervision they required to provide them with the knowledge and skills to provide care in a safe and effective way.

Is the service caring?

Requires Improvement

Some aspects of the service were not caring.

Most people told us they had regular care workers although this did vary more in the evenings and at weekends

People told us, in general, the care workers were kind and caring and treated them with dignity and respect when providing care. A few people also told us staff were not always caring.

The care plans identified each person's cultural background, personal history and any religious beliefs so staff had all the information they needed to care for people appropriately.

Is the service responsive?

Requires Improvement

Some aspects of the service were not responsive.

Care plans identified how the person wanted their care provided including their likes and dislikes but some information was not consistent across the sections of the care plan.

The provider had a complaints process and people were aware of how to raise concerns.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well-led.

The provider had introduced new quality assurance processes. These were helping to improve the quality of the service and to meet legal requirements, but there was still more to do. For example, the medicines audit did not provide robust information so issues could be identified and addressed.

People and care workers told us they felt the service was well-led.

Genesis Recruitment Agency Ltd; Nursing & Domiciliary Care; West London

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 the 22 and 23 October 2018 and was announced. The provider was given two days' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available.

Two inspectors undertook the inspection and an expert-by-experience carried out telephone interviews of people who used the service and relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who has used this type of care service. The expert-by-experience at this inspection had personal experience of caring for older people.

Prior to the inspection we reviewed the notifications we had received from the service, records of safeguarding alerts and previous inspection reports. Registered providers need to send notifications to the CQC about certain changes, events and incidents that affect the service or the people who use it.

The provider completed a Provider Information Return (PIR) in September 2017. 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 the inspection we spoke with the registered manager who was also the provider's director, a quality improvement consultant, deputy manager and the care coordinators. We reviewed the care records for 14 people using the service, the visit summary records for six people, the employment folders for three care workers, training records for all staff, visit rotas for two days and records relating to the management of the service. The expert by experience contacted 10 people who used the service and one relative by telephone. We sent emails for feedback to 55 care workers and received comments from 14 of them.

Requires Improvement

Is the service safe?

Our findings

During the previous inspection we saw the provider had a procedure for the administration of medicines but some people's medicines were not being recorded appropriately. During this inspection we saw the provider had made improvements but some people's medicines were still not being recorded appropriately.

The medicines administration record (MAR) chart for one person indicated they should have a medicine used to control seizures administered twice a day, but the MAR chart for August 2018 showed this had only need administered once a day. There were also four days during August 2018 where it had not been recorded as being administered by the care workers. The MAR chart also showed two other medicines had not been signed as administered on these four days. We saw three other medicines administered at the same time had been recorded for those dates. There was a form attached to the MAR chart where care workers should record the reason why any medicines had not been administered but this had not been completed for the four days we identified.

We saw the MAR chart for another person identified there was one medicine that had been prescribed to be administered once a day but there was no record for it on the MAR chart for the whole of September 2018. The administration of other prescribed medicines had been recorded during September 2018 and the form to record medicines that had not been administered, had not been completed.

These MAR charts had not been checked as part of the audit process introduced by the provider so the issues had not been identified and investigated.

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

People we spoke with confirmed that, if they needed help with their medicines, the care workers supported them with their medicines as agreed in their care plan. The registered manager confirmed a pharmacist had carried out training on the administration of medicines for the field care supervisors and it was scheduled to be carried out with care workers. Care workers had also completed administration of medicines training as part of their induction and refresher training programme.

The provider had guidance on the management of people's medicines and this had been reviewed in July 2018. There were also copies of the guidance produced by NICE and the Royal Pharmaceutical Society in relation to the administration of medicines, available in the office.

The provider had introduced a new MAR chart format and a system for care workers to record if a medicine had not been administered and the reason why.

During the inspection on June 2018 we saw risk assessments and guidance for care workers was in place as to how they could reduce possible risks but the level of the risk had not always been assessed based upon the person's individual needs. At this inspection we saw the risk assessments and risk management plans

had been reviewed and the level of risk had been assessed based upon the person's current health and care needs as well as any other input from healthcare professionals. For example, we saw the level of risk in relation to falls was based upon when the last fall occurred, if there were any medical conditions which increased the risk of falls and if equipment was in use, such as hand rails. There were control measures identified as part of each risk management plan to provide care workers with guidance as to how to reduce the risk for example ensuring the floors were kept clear to reduce the risk of falls.

During the inspection in June 2018 we found the provider was not deploying care workers to ensure visits took place at the time agreed with the person receiving care. At the inspection in October 2018 we found the provider had made changes to their system to ensure visits occurred as planned and if there was a change to the visit time the reason was recorded.

We spoke with people who use the service about their experience of visits being made at the agreed time and most people told us visits were usually on time but several people commented visits were sometimes late and a couple of people reported missed calls. "She is generally on time", "[The care workers] don't often come at the time I expect them- they get held up with buses etc… I never know when to expect them. I need them to help me and so I just have to wait" and "They generally come on time, only very occasionally 10 minutes late and they always stay for the full time.

The provider had an electronic call monitoring system (ECMS) for care workers to record their visit. This included the care workers logging on the ECMS to record their arrival time and then log the time their visit ended.

At the previous inspection in June 2018 there were visits which did not always take place at the agreed time as planned. During this inspection the quality improvement consultant explained a new monitoring system had been introduced to record any visits which did not occur as planned and to identify the reason so see if any changes were needed to the person's planned visit time.

The ECMS records for the 6 October 2018 indicated 201 visits were recorded and we saw there were 14 visits which occurred more than 45 minutes earlier or later than planned on the rota. From the 14 visits we saw seven were recorded on the monitoring spreadsheet with the reason for delay and action taken and seven were not recorded. We saw the ECMS records for 10 October 2018 showed that from the 212 visits there were 17 visits which occurred more than 45 minutes earlier or later than planned on the rota of which 13 were recorded on the monitoring spreadsheet with the reason for delay and action taken and four were not recorded. We spoke with the quality improvement consultant about the reasons why the 11 visits we identified as not occurring at the agreed time were not recorded. They provided the reasons for the change in visit time for these 11 visits and confirmed this information would be added to the care plans and the ECMS.

We saw, from the records from the ECMS, there was no evidence of visits being planned without adequate travel time and there were no visit times which overlapped with the next visit scheduled for the care worker.

The provider has implemented a process to enable them to monitor the visit times and to identify and act if any issues in relation to early or late visits.

The provider had a safe recruitment process in place to make sure the care workers they employed were suitable to work with people using the service. During the inspection we reviewed the records for three care workers and saw the information required by the provider was in place. The registered manager confirmed that as part of the recruitment process they would request a full employment history, the details of two

references, proof of the applicants address and their right to work in the United Kingdom. A Disclosure and Barring service enhanced check in relation to criminal records was carried out before the applicant began training and it was renewed every three years.

We asked people if they felt safe when they received support in their home from the care workers and we received a range of comments with some people saying they did feel safe while others told us sometimes they did not always feel safe. Their comments included "I feel safe, they know what they are doing which is a good start. If there are any new carers I do have to go through things with them especially about the dressing and the bandages" and "I usually have the same carer once a week to help me wash my hair and have a bath. I do feel safe, she is very nice and we get on quite well. She helps pull me up and knows how to use the bath seat." One person told us "I don't always feel safe and comfortable with some of the carers, some seem as if they are in a hurry and just want to get away."

During the inspection we saw the provider had reviewed their safeguarding policy in June 2018 and it referred to the Department of Health guidance "No Secrets". The safeguarding records we reviewed demonstrated the provider cooperated with the local authority and the police when necessary to investigate any concerns.

The provider had a process in place to record, investigate and respond to incidents and accidents. We saw when an incident and accident occurred information was recorded and actions were taken, when required, to identify any changes in support need or to reduce risk of reoccurrence.

People we spoke with confirmed all care workers wore gloves and aprons when required during their care visits. One person commented "They have their own gloves and aprons when bathing me. The agency supplies them all. A relative told us "The care worker leaves gloves in a basket we have and always uses them and I have seen that she wears an identity badge." Care workers were provided with personal protective equipment such as gloves and aprons. The training records showed care workers had completed infection control training as part of their induction and ongoing training.

Requires Improvement

Is the service effective?

Our findings

During the June 2018 inspection we saw the provider had made some improvements but was still not working within the principles of the Mental Capacity Act 2005. At the October 2018 inspection we saw the provider had made further improvements but some areas still required further work.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA.

We saw the provider had introduced a new form titled 'Mental Capacity Act: Test of Capacity' based upon the MCA which was to be used in addition to the existing assessment which was part of the care plan. The new test did not indicate the person's ability to consent in relation to a specific decision or area of care to be provided but was a general assessment of the person's capacity to consent to any care. This meant the person's ability to consent to a specific aspect of their care had not been assessed and the general decision about the person's ability to consent to care which had been made was not in line with the principles of the Act.'

We recommend the provider review and implement guidance in relation to the Mental Capacity Act 2005.

The original assessment form which was part of the care plan had been amended to include separate sections in relation to the person's ability to consent to personal care being provided, administration of medicines and other aspects of support which might be provided such as shopping and domestic cleaning. This form indicated if the person had the ability to consent to these aspects of the care provided.

A new consent to care and treatment form had been developed to confirm the person's agreement to their care plan, the administration/prompting of medicines and personal care. We saw these forms had been signed by the person using the service. The form included a section for a best interest decision to be made in relation to the provision of care if the person had been identified as not having the ability to consent to their care.

During the June 2018 inspection we found that the assessments of care worker competency in relation to moving and handling and the administration of medicines were not robust. During this inspection we saw the provider had reviewed the process for assessing the competency of care workers for these two areas. The senior staff who carried out the assessments of care workers competency had completed additional training in relation to administration of medicines and moving and handling which was confirmed by the certificates we saw.

We spoke with people using the service and asked them if they felt the care workers had received enough training to provide their care. We received mixed comments from people which included "Sometimes I feel,

it's hard to put into words, that they [care workers] haven't had enough training. They don't all seem to know what to do" and "They do get training as they tell me about it. They will say 'Oh I won't be here tomorrow as I have got some training' I think quite a few are doing NVQ level two and level three. There is one whose English is quite limited but this is offset by her being very kind and she gets it in the end."

During the inspection we reviewed the personnel records for three care workers and the training records for all the staff employed by the service. The care worker records demonstrated that regular supervision meeting was being undertaken with the care worker's manager. The notes from these meetings were recorded with any issues and further actions identified. The records also showed that annual appraisals were completed to review the development and performance of individual members of staff.

The training records showed all the care workers were up to date with the training identified as mandatory by the provider as well as identifying when they completed each course and when they were due to undertake the next refresher course. Care workers had also completed the Care Certificate to support their understanding of their role. The Care Certificate is a nationally recognised set of standards that gives staff an introduction to their roles and responsibilities within a care setting.

When a referral was received from the local authority an assessment of the person's needs was carried out to ensure they could be met by the service. Once the care package was accepted a field care supervisor would visit the person to complete a detailed needs assessment and this information would be used to develop the care plan and risk management plans.

Where this was part of the care plans, care workers helped people to prepare and/or eat their meals. One person told us "They do meals and drinks for me and always ask me what I want and make sure they leave me with a drink." We saw the section of the care plan which described the care activities required during each visit identified if the care worker was required to provide support with meal preparation, eating and providing drinks. Care workers we spoke with confirmed they had completed food hygiene training and this was supported by the training records.

The care plans for each person identified their GP and any other healthcare professional that was involved in their care. The care plans included section on the person's medical history covering their physical health and any sensory issues such as visual or hearing impairment. A person told us "A couple of times I've not been well when the carers have been here for example about a year ago I was feeling unwell and she seemed to really care and called her office and then called the doctor for me." We saw that staff liaised with people's GPs, district nurses and other healthcare professionals as well as social care services to make sure people had the care and support they needed.

Requires Improvement

Is the service caring?

Our findings

Most people we spoke with told us they had regular care workers although this did vary more in the evenings and at weekends. Their comments included "I do get different carers", "I have a regular carer and at the weekends there is another girl who is generally the same person" and "I have a regular carer for six days a week and a different one on a Sunday." A relative commented "My family member has a regular couple of carers. I wouldn't like lots of different people knowing the code to the keypad. The main one is fantastic and always on time and if my relative has to go to hospital they will come in early, very obliging. They are really, really good"

People we spoke with found the care workers to be caring and kind although there were some exceptions to this. They told us "Most of them are kind in the way they take care of me and all the dealings with cleaning me and toileting", "I do feel comfortable with the carers, they do seem to genuinely care and they show some interest in me. We get on well for example [care worker name] has been taking English lessons. I trained to teach English and so we have conversations about English language. We have a laugh. They are respectful for example this morning the care worker was washing me and her phone rang. I said, 'Do you want to get that?' and she said 'No, I am washing you and so I will take it later'", "They are very good- I couldn't ask for better. The way they treat me is so good, they show compassion and real care. Some carers are just in it for the money but my carers genuinely care", "My regular carer is wonderful- she gets all my meals and does my bed and everything I need and we have a chat and a laugh. It couldn't be any better."

Other people told us their experience depended on which care worker visited. They said "Some of the carers are charming but some are not so charming. Some just seem more understanding and others just want to get it over with and get away. They are all different. Some chat and others don't. If they are in a hurry they don't really talk" and "The main care worker shows an interest in me but the others don't show any interest, they just come in and do what they have to do. I hate to say these things but I worry about people who are scared or can't say the things I am saying."

A relative commented "My family member has early dementia but they talk to him as an adult and don't talk down to him. They are marvellous and know how to use all the equipment. They put everything back where they find it and hang all the towels up. They are very trustworthy, I really trust them to look after my relative."

Two people we spoke with told us the care workers sometimes told them the names of other people they were providing support for which did not always ensure their privacy and dignity. They said, "They only talk about others when they say, 'sorry I am late but (Name of another person) refused to wash this morning' They only use the first name, not so I can identify the person. There is one person before me who keeps getting up and falling down so my carer can be late because of that" and "Sometimes they talk about other people, sometimes they mention names and sometimes they don't, it's a lack of confidentiality."

We asked care workers how they would ensure the dignity and privacy of the person they were supporting when providing personal care. They provided similar answers relating to ensuring doors were closed, check with the person to ensure they were comfortable and happy for the care to be provided and not to rush the

person. Their comments included "To ensure people's dignity and privacy is maintained by firstly announcing myself upon entering the house. By respecting their choice in how they would want the care, allowing them to do what they can during personal care. Be respectful at all times" and "I would knock on the door and announce that I was in their homes, I make sure that I greet them with respect, I ask them what they would like to eat, drink, wear and I communicate with them all the time and listen to what they have to say. Encourage them to be independent and to help themselves."

The care plans identified the person's religious and cultural needs as well as the name they preferred care workers to call them. The care plans also indicated if the person preferred a male or female care worker so their choices could be met.

Requires Improvement

Is the service responsive?

Our findings

During the inspection we saw care plans were detailed and provided information as to how people wished their care to be provided. The care plans were made up of separate sections which provided care workers with a range of information about the person which included their background, health, mobility, mental capacity and nutritional requirements. A detailed description of the care activities to be carried out during each visit was included as part of the care plan. The descriptions included details of how the person wanted their care provided, for example where they preferred to eat their meals and if they wanted personal care provided in the bathroom or bedroom.

We noted that in some of the care plans information was not always consistent across all the sections. The description of the care activities to be completed during each visit stated the care worker should administer the person's medicines. This was also indicated in the medicines section of the care plan. Both of these documents were developed in May 2018. We saw a risk assessment had been developed in September 2018 which identified the care workers had been requested to leave the person's late evening medicine out for them to take before they went to bed to help the person promote their independence. The risk assessment identified how care workers should monitor that the person had taken the medicine and when this should be reviewed to assess if it was a suitable process but this information had not been updated in the care plan or care activity description.

We raised this with the quality improvement consultant who confirmed the care plans would be reviewed and the provider was in the process of implementing an audit of the care plans.

All the people we spoke with confirmed they had a care plan in their home and most people could recall the care plan being discussed with them by a member of staff. People's comments included "Everything is in the care plan- I've seen it but I had to amend it- I have written on it to amend it for example it said to prepare me a meal but they actually only need to get it out of the fridge and I prepare it myself" and "Now and again they come out to see me from the office. [Staff member name] came to bring my new care plan before and asked me to read and sign it and [Staff member name] has turned up on occasions. They seem fine and I do feel they listen to what I have to say."

People we spoke with told us they felt the service was flexible to meet their changing needs and to provide support in an emergency. One person said "They have been flexible as I have improved in strength and now only need one carer on each visit instead of the previous two. I can now pivot onto the commode so no longer need the hoist. They were able to change the care package." A relative commented how the agency was flexible to help their family member when there was no one else to help, by sending a care worker at short notice. They said, "[Staff member] from the office came to see us and she is lovely and helpful. If my relative did need any help they would be there."

As people were not being supported to meet their end of life care needs at the time of the inspection we saw the care plans did not identify the person's wishes in relation to their end of life wishes. The provider had arrangements to meet people end of life care needs should this be needed.

People we spoke with told us they knew how to make a complaint if they had any concerns about how their care was being provided. A relative told us "I have never had to complain but I would if needed and I think they would listen and take it seriously." During the inspection we looked at the records for three complaints received since the last inspection and we saw when complaints were received they were appropriately recorded, investigated and responded to in line with the provider's procedure.

Requires Improvement

Is the service well-led?

Our findings

At the previous inspection in June 2018 we found the provider had made some improvements in the quality assurance process but the systems were still not robust enough to identify areas requiring improvement. During this inspection we saw the provider had introduced a range of quality assurance processes.

However, the audit of the MAR charts was not always carried out in an effective way to identify areas where improvements were required. The quality improvement consultant explained that, at the time of the inspection, the audit process for MAR charts was that they only checked a selection of completed charts each month and not all the MAR charts they collected from people's homes. When we looked at the MAR charts that had not been reviewed as part of the audit process we identified issues with these records.

We discussed this with the registered manager and quality improvement consultant and they confirmed that from October 2018 all the MAR collected each month from people's homes would be audited so any discrepancies could be identified and addressed to prevent reoccurrence.

Whilst there have been some improvements around the way the service was assessing people's mental capacity, we found during the inspection that there was still room for more improvements. This was because the provider's quality assurance systems had not fully identified the issues we found in this regard.

The checks and audits on care plans had not yet ensured that where there were discrepancies and inconsistencies that these were identified and addressed in a timely manner.

The above was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

Where the MAR charts had been audited we saw the audit forms identified if there were any issues with how the medicines were recorded. For example, we saw the audit of one MAR chart identified there had been dates during the month where the administration of medicines had not been recorded. The reason for the missing information had been looked into and confirmation from the local authority that the person was in hospital on those dates, was attached to the audit form.

We saw the quality improvement consultant had introduced audits for financial transactions carried out on behalf of people using the service and the communication sheets which were completed by care workers to record the support provided during each visit. We saw the records of these audits and where an issue was identified in the recording of the care provided it was raised with the care worker and this was included as part of the audit. There was also a process for carrying out quality monitoring visits to obtain feedback from people using the service in relation to the care they received. Every three months either a quality assurance survey or a quality visit was completed to assess the care. We saw copies of these quality reviews in the person's folder and if issues were identified actions were recorded.

We spoke with people who use the service and asked them if they felt the service was well-led. We received

positive comments relating to how well-led the service was run. One person told us "The supervisor comes and collects the book every so often. I think [staff member's name] is the main supervisor. One of the senior people came out as my carer this morning. I think there are two or three ladies in the office who answer the phone and I can always get through if I need to. I have phoned out of hours and I think the call must transfer from the main number. They do answer." A relative we spoke with told us "I can get through to the office and if the person I need to speak to isn't there I can leave a message and they always phone back."

We asked care workers if they felt the culture of the organisation was open and fair and they felt it was. Their comments included "They are good in guiding and supporting in any situation", "I think the organisation is fair to the staff, they will keep us informed and updated about changes. I feel respected and the staff will encourage me and acknowledge my hard work. The manager's and director's door are always open to staff", "I feel that they are fair and open, they are good to me and keep me up to date with information and training" and "Yes, I am very happy how the office is running." One care worker did comment they did not feel the organisation's culture was fair and they said, "The culture is not fair and open we are always being given negative feedback and always complaining that the job we do is not good enough."

Care workers felt the service was well-led. Their comments were positive and included "Very well led. The concerns raised are respected and dealt with in an appropriate manner by the manager", "When I call the office regarding an incident I receive support and guidance immediately", "It is a supportive environment", "Yes, it's very good. They care about the staff and the service users, consider us as individuals and will respond to issues and always try and keep everyone happy", "Yes, I do. The director's door is always open and he is willing to listen to his staff" and "Yes, the office management is very accessible and listen to any issues I have and are always willing to resolve issues to ensure I do my job effectively."

The registered manager organised regular meetings for the care workers and office based staff. We saw a meeting had been organised in August 2018 with six different sessions to enable as many care workers as possible to attend. A meeting for the office staff was organised in July 2018 where the use of the out of hours telephone line and coordinating the electronic and paper care records was discussed. Notes from the meetings were taken and circulated.

The service had a nominated dignity champion and medicines champion. The registered manager told us they attended registered manager forums arranged by the local authority. They also monitored the skills for care website to keep up to date with best practice.