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Family Care Solutions

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 23 June 2016 and was announced.

Family Care Solutions provide care and support to people living in their own homes. At the time of our inspection, the service was supporting primarily older adults living within areas of Stockport and Cheshire. The service was providing support to 58 people at the time of our inspection. The service was not required to have a registered manager. The provider was an individual who had responsibility for the day to day management of the service.

We last inspected the service on 27 January 2014 when the service was registered at a different address. At that time, we found the service was meeting the standards of the regulations inspected. At this inspection, we identified two breaches of the regulations, which were in relation to safe recruitment procedures and taking measures to reduce potential risks. You can see what action we told the provider to take at the back of this report. We made three recommendations, which were in relation to developing systems to monitor the safety and quality of the service, ensuring policies are up to date and recording of complaints.

People spoke positively about the service they received from Family Care Solutions. They told us the service was reliable and friendly and that staff were good. Staff told us they worked with the same people on a consistent basis and this was confirmed by the people we spoke with.

Staff, including managers were able to demonstrate that they knew people very well. We found staff and managers spoke about people in a kind, caring and respectful way.

There were sufficient numbers of staff to ensure all calls could be covered. We received one report of a missed call, however we were told this was not a regular occurrence. People told us staff turned up on time, or that there were only short delays, which could be due to traffic or staff being delayed on the previous call.

There was a generic, pre-populated risk assessment in people's care files. These had not been personalised to individuals, so it was not clear that full consideration to potential risks had been given. However, we did see that where specific risks had been identified, such as in relation to self-neglect or behaviour that challenged, that additional risk assessments had been put in place.

Staff had received training in a variety of areas including infection control, safeguarding and the Mental Capacity Act. However, there was no recorded practical training in moving and handling and there were not always clear instructions in the care plan for staff to follow in relation to how to hoist people safely. Staff received an induction and were able to shadow more experienced staff until they felt confident prior to starting to lone-work.

People had care plans in place and there was evidence these had been reviewed and updated when required. There was no evidence of regular reviews if no required change had been identified. However, the

provider had recently introduced a new electronic care management system, and we saw this had started to be used to help monitor and record when reviews were due or had taken place.

Staff told us they felt well supported and able to approach a manager with any concerns. They spoke highly of the quality of the service Family Care Solutions provided people.

People told us they would be confident to raise a complaint if they felt this was necessary. People we spoke with who told us they had made complaints said that any issues had been resolved quickly and to their satisfaction. The provider had not recorded informal complaints, so it was not possible to see what actions had been taken. They told us they had never received a formal complaint.

We saw staff had had a criminal records check before they started work. However, there were some gaps in records which would help the provider demonstrate that staff's suitability for the role had been given due consideration. One staff member who had started shadowing other staff had started before references had been received and another staff file did not document the reasons for a gap in their employment history. We also found minutes from interviews had not been retained.

Staff demonstrated a good understanding of how to support people's independence whilst balancing this against any potential risks. People told us staff always asked for their consent before providing care and were respectful of their privacy and dignity.

We saw the provider had researched good practice and sought advice from a professional in relation to providing effective support to meet a person's needs. This had been used to produce guidance for staff.

There were some systems in place to help the provider monitor the quality and safety of the service. These were basic however and we have recommended the provider further develops these systems.

People, staff and the provider all talked about the benefits of the agency being small and local. For instance, we were told if someone rang the office, they would be talking with 'the boss' and they would work quickly to resolve any issues.

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 consistently safe.

Risk in relation to people's care had been assessed. However, there was no formal practical moving and handling training, and clear instructions for staff on how to use hoists were not always recorded in people's care files.

Staff had had a criminal records check and interview prior to starting employment. However, one staff member had started shadowing before their references had been returned and no records of interviews were kept.

There were sufficient staff available to attend all calls. The provider had taken appropriate actions to ensure people's safety when they had not been able to attend calls due to reasons outside their control.

Is the service effective?

Good

The service was effective.

People told us staff completed all tasks required during their calls.

Staff had a good understanding of how to seek people's consent and in relation to considerations around mental capacity.

Staff received an induction and had opportunity to shadow more experienced staff before they started to lone- work. Staff informed us the manger had told them they could shadow for as long as they felt was required for them to be confident and competent.

Is the service caring?

Good

The service was caring.

People told us they were visited by the same staff on a consistent basis, which helped them develop caring relationships. Staff were able to demonstrate that they knew the people they provided support to very well.

Staff had a good understanding of how to effectively support people's independence whilst maintaining an awareness of potential risks.

People told us staff communicated with them effectively. Everyone we spoke with felt their privacy and dignity was respected by staff.

Is the service responsive?

Good

The service was responsive.

People told us they would feel confident to raise a complaint. The people we spoke with who told us they had raised issues told us the provider took prompt action to resolve these concerns. However, records of informal complaints had not been maintained.

People's needs had been assessed prior to them starting to receive a service. Staff told us care plans contained sufficient detail to enable them to understand what care and support a person required.

The provider talked about providing 'holistic support' that met people's physical health needs as well as their social support needs. Staff had explored options for supporting people to access social activities and the local community.

Is the service well-led?

Good

The service was well-led.

People and staff spoke positively about the management of the service. They told us managers were approachable and supportive.

Staff told us they were happy in their roles. They told us they thought the quality of care provided was very good.

There were some checks in place to help monitor the quality and safety of the service, although these were not always formally recorded. The provider had recently introduced an electronic care management system and a second care coordinator had been recently employed to help support the implementation and development of systems and procedures.

Family Care Solutions

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 23 June 2016 and was announced. The provider was given 48 hours notice. This was because the location provides a domiciliary care service and we wanted to ensure someone would be available at the office to facilitate the inspection, and in order to help plan the inspection effectively.

The inspection was carried out by one adult social care inspector. A second adult social care inspector assisted in making phone calls to people using the service shortly after the inspection.

Prior to the inspection, we reviewed information we held about the service. This included any statutory notifications the service had sent us. These are notifications the service is required to send us about significant events such as safeguarding, serious injuries or events involving the police. We reviewed any information about the service that had been shared with us via email, phone or through a 'share your experience' form on the CQC website.

Before the inspection, the provider completed 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. We sought feedback on Family Care Solutions from commissioners of the service, Stockport Healthwatch and Stockport Council's quality assurance team. No concerns were raised with us in relation to the service.

During the inspection, we spoke with five members of staff, including two care staff, a care coordinator, the provider (who was an individual) and a second manager. We spoke with one person who was using the service. We spoke with an additional three care staff, three people and four relatives by phone in the week following the inspection site visit.

We reviewed records relating to the care people were receiving, which included five care files, medication

administration records (MARs) and daily records of care provided. We also looked at records related to the running of a domiciliary care agency including; five staff personnel files, records of training, records of staff supervision, rotas and policies.

Requires Improvement

Is the service safe?

Our findings

There were sufficient numbers of staff available to allow all calls to be covered. We calculated the number of available staff hours against the number of support hours being provided by the service and found there was flexibility to allow cover to be provided for staff leave or sickness. The provider told us they had facilities to electronically monitor calls, but had chosen not to do this as they worked on a trust basis with staff and had not had issues with missed calls. People and relatives we spoke with told us the service was reliable. We received one report of a missed call, which a relative told us had been due to a breakdown in communication. They said however that the service was 'very good' and had managed to keep to agreed visit times '99.9 percent' of the time.

The provider told us they did not have a written policy or procedure in relation to missed visits or non-access to people's homes during scheduled visits. However, managers were able to give us details of the steps they would take and provide us with examples of when they had followed such procedures. For example, the provider discussed a recent situation where there had been localised flooding that had prevented care staff from reaching people. The service had contacted the people they were not able to reach and had contacted the police to undertake welfare checks if this had been required. Staff told us they were always able to get in contact with an 'on-call' manager for support or advice if required.

Everyone we spoke with told us they felt safe with the staff that provided them with support. The provider had not notified us of any safeguarding incidents within the 12 months prior to the inspection. We discussed safeguarding with the provider who demonstrated an understanding of the kind of concerns that would need to be raised as a safeguarding alert with the local authority. Staff we spoke with also demonstrated a good understanding of how to identify signs of potential abuse or neglect. They were able to provide examples of instances where they had had concerns over a person's welfare and had raised the concern appropriately with a manager. Staff and the managers we spoke with confirmed there had been no safeguarding incidents within the past 12 months.

We found the assessment of risks related to the provision of care was variable. There were generic risk assessments in people's care files that contained pre-populated details in relation to identifying and controlling risks in relation to areas such as the environment, infection control, falls and clinical waste. These had not been personalised to reflect the specific needs and risks in relation to each individual, so it was not clear which risks were relevant or whether identified measures to reduce risk were appropriate or required. The care file of one person who had recently started using the service did not contain any specific risk assessment document; although we could see, there had been consideration of potential risks during the initial assessment.

However, we saw other care files that contained more in-depth and personalised risk assessments. For example, one person's care file contained several risk assessments that covered specific tasks and potential risks such as behaviour that challenges, self-neglect, wandering, nutrition and financial abuse. These risk assessments contained guidelines that would help ensure staff were aware of how to manage and reduce any potential risks.

Three people's care plans we reviewed indicated they required support using a hoist. We saw a moving and handling assessment had been completed by an occupational therapist for two of these people. However, the third person did not have a moving and handling assessment in place. A moving and handling assessment is important to help ensure staff are aware of details such as what loops on a sling to use to make sure the person is hoisted safely. The provider told us this information would be at the person's house though we were unable to confirm this. They told us they had been unable to carry out an assessment but that the care coordinator had carried out one of the calls to review the techniques used and had been happy with the arrangements.

Staff we spoke with confirmed they supported people using a hoist and told us they had undertaken on-line training. We asked the provider about the provision of practical moving and handling training, which is important to ensure staff have the skills and competence to hoist people safely. They told us one of the care coordinators was a trained moving and handling assessor, and would support staff to help ensure they were competent with moving and handling tasks. However, they confirmed there had been no formal practical moving and handling training, as there was no space for the equipment required at their office. This was a breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had not done all that was reasonably practicable to assess and reduce risk and to ensure staff had the skills required to hoist people safely.

People we spoke with told us staff always had adequate supplies of equipment with them such as gloves and aprons. Staff we spoke with were aware of measures to take to reduce the risk of spread of infection. They told us for example that good hand hygiene was important and that they would wash their hands frequently and after any care tasks. They also told us they carried hand gels with them and would use these if they had been unable to wash their hands with soap and water.

We looked at records of medicines administration and prompting. Staff had completed the records consistently, and they clearly showed the medicines people had received. The provider told us they had recently noticed that staff had not always completed medicines records consistently and they told us they had changed the medicines administration records to help address this. We saw the provider kept a record of any medicines errors and the actions taken. Most of the errors had been clerical errors; however, we saw one instance where carers had not administered a dose of medicines. The provider had identified this error, sought advice from a pharmacy and had addressed the issue with the staff team to help ensure there was not a repeat incident. This showed the provider was taking appropriate actions to help ensure people were supported with their medicines in a safe way.

We looked at staff personnel files to see if there was evidence of safe systems having been followed in the recruitment of staff. We saw all staff had a disclosure and barring service, (DBS) check in place prior to them commencing employment. DBS checks provide the employer with information in relation to any criminal record or whether the individual is barred from working with vulnerable people. This helps employers make safer decisions when recruiting care staff.

All staff had identification in their personnel file and they had completed an application form for employment. We found there was a gap in one staff member's employment history. Following discussion with the provider, we were confident they were aware of the reasons for the gap. However, this had not been documented in the staff member's records. The provider told us any prospective staff were interviewed if their initial application was successful. Staff confirmed they had received interviews prior to being offered a post. One staff member said; "Yes I had an interview. They explored my experience, competency and past work history." However, we could not locate any records of staff interviews in personnel files and the provider confirmed they had not kept such records. This meant it was not possible for us to determine what

steps the provider had taken to ensure staff members were suitable to the job role. We found that employment references for one staff member had not been received. The provider told us this staff member had not officially started employment. However, we saw they were on the rota and were 'shadowing' other staff on the day of our inspection. These gaps in documentation related to people's employment were a breach of regulation 19 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Good

Is the service effective?

Our findings

People we spoke with told us they thought staff were competent to provide the care they needed, and said staff completed all agreed tasks during their visits. One person told us; "They do everything I want them to do. The carers seem trained so I have no problems with them." Another person noted that staff who had worked in care homes previously appeared more competent, but said; "They [care staff] are very conscientious and do what is expected."

Staff told us they had received training in areas including infection control; dementia care; safeguarding; medicines, food hygiene and the mental capacity act. We asked the provider for a summary of training staff had received. This indicated that of the 18 care staff listed; 14 (78%) had completed safeguarding training; 12 (67%) had completed medicines and moving and handling (theory) training; 8 (44%) had completed first aid training and two (11%) had completed infection control training. The provider told us additional training had been provided and that other than the office staff and new starters, staff had all completed the training identified as mandatory. The manager told us the service had switched to a new training provider in March 2016 and that the training summary only indicated training provided since this date. They told us the intention was to ensure all staff completed training with this new provider and that the records had been 're-set' from March 2016. We saw training certificates in staff personnel files that supported that staff had received training in areas such as safeguarding, medicines and infection control.

Staff we spoke with confirmed they had completed training in areas including dementia care and the Mental Capacity Act (MCA), which were not indicated on the training matrix. We also saw training certificates in staff files, which supported what staff had told us. Staff told us they felt they had received sufficient training to undertake their role effectively, and said training was discussed with them during supervisions.

Staff told us they received supervision from the manager and found this a useful exercise. One staff member said; "Supervision is useful. We talk about how we're finding the job, if we're happy with our hours, calls, clients and staff." We looked at records of supervision, which documented discussions the manager had had with staff. We saw the manager had provided staff with feedback on their practise and discussions had been held around training and the needs of individual's the staff were supporting. This would help ensure staff were able to discuss any issues they may have, and receive practical advice from the manager. Staff also talked about there being a good system of informal support and supervision in place, and told us a manager was always at the end of the phone and willing to listen to them.

Staff we spoke with told us they had had opportunity to shadow other more experienced staff members before they started lone working. One staff member told us they had shadowed for two weeks, and the manager had agreed to them shadowing for an additional week, as they did not yet feel confident. Another staff member we spoke with told them it was up to them how long they wanted to shadow, and had said it was what they felt comfortable with. This showed the service was working adaptively to ensure staff received the required level of support before they started lone working. One recently recruited staff member told us a manager had been out to visit them during a call and check their competency. The provider confirmed they completed competency checks, but said these had not been recorded. We saw 'induction

checklists' were in place in staff files and had been completed and signed off by staff and the manger. The checklists covered areas including values of the company, reporting bad practice, fire safety and policies and procedures. This would help ensure staff had the information they required before they started to lone work.

The provider told us they were building a library of information in relation to specific conditions such as dementia, stroke, autism and end of life care. We saw information from a variety of sources had been brought together and staff we asked were also aware of this resource. The provider spoke with us about how they had researched and sought advice from a professional in relation to effectively managing a person's behaviour that could challenge the service. We saw this information and the guidance that had been produced as a result to help staff provide effective support. The provider told us that staff had used tools such as memory boxes and collages of people's old photos as an effective way of facilitating engagement with some people who were living with dementia. Staff we spoke with were aware of the ways in which dementia could affect the people they were supporting, and one staff member spoke about the need to adapt the care people received to people's changing needs.

Two people we spoke with told us they were supported by staff to prepare meals. One person told us; "They make what I want for my breakfast." Another person told us staff helped them prepare breakfast and they confirmed that staff always asked what they would like. We saw guidance on people's dietary requirements was recorded in people's care plans. Staff told us they had monitored one person's food and fluid intake but they were no longer required to do this due to this person's health having improved. We saw records had been kept of this person's dietary intake. We saw guidance from speech and language therapists (SALTS) was kept in people's care files for staff to refer to help ensure people received the support they required with eating and drinking. Staff we spoke with were aware of this guidance.

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

The provider told us no one being supported by the service was subject to any restrictive practices. They were aware that authorisation from the Court of Protection would be required if there was a need to restrict someone's liberty. Staff we spoke with demonstrated an awareness of the principles of the MCA. They told us they would always explain what they were doing and would seek people's permission before providing any care or support. People we spoke with confirmed this was the case. Staff talked about one person they supported who could at times refuse care and support. They told us they would respect the person's decision and would return at a later point, or try sending a different member of staff. Another staff member spoke about considering less restrictive options, such as providing a strip-wash to someone who did not want support with a full bath or shower.

Good

Is the service caring?

Our findings

People we spoke with talked positively about their relationship with staff who supported them. Comments included; "I get all the help I need. It's just natural;" "They are caring and can communicate effectively. They have a good attitude;" and "They are very friendly."

People told us they knew the staff who came to support them, and staff confirmed they worked with the same people on a regular basis. This would help staff get to know people and help them develop caring relationships. One relative told us their family member had received support from other care agencies in the past, and commented that they had never had the same level of consistency in the staff team as they had with Family Care Solutions. One person told us; "The same people visit. The young man this morning has been coming for years." Another person said; "You get to know the staff that come to your house. You look forward to them coming."

The provider told us they had set up a key-worker system where certain staff members would take a lead role in providing a person's support. They said they would consider people's relationships when assigning key-workers, as they were aware certain staff members had built up particularly good relationships with people they supported, or had shared interests. For example, they spoke about one person who liked the staff member supporting them to spend some of their support time watching a TV programme that they both enjoyed.

From our discussions with staff and managers at the service, it was clear that they knew the people they supported very well. Both the provider and staff members talked about the benefits of being a relatively small agency, which allowed them to quickly get to know the people using the service. The provider told us; "Being a small agency means we are close to the clients." A staff member said; "I've worked for different agencies and can't fault it. We always talk about people with a lot of warmth. It's all human."

People told us they felt staff supported them to be as independent as they could be. One person said; "I'm getting more and more able. They appreciate that and only intervene when asked." Staff had an appreciation of the need to balance risk and a duty of care effectively against supporting people's independence. One staff member told us; "We help people keep their independence. We will help people stay safe but don't take over. It's important to value what people can do." Another staff member talked about the importance of allowing people time to do things themselves. They provided an example of supporting a person to dress himself; even though this could take much longer than if, they did everything for that person.

People we spoke with told us staff communicated with them effectively. We saw basic details about people's communication were recorded in their care plans, including any communication aids such as hearing aids that were required. Staff told us they would look for non-verbal communications or gestures if people had impaired ability to communicate verbally. They also told us they had used communication aids such as cue cards to support effective communication with people. One staff member talked about putting a 'memo board' in place for one person to help them manage their appointments. They said this had been put in

place, as they had not liked using a diary.

Everyone we spoke with felt staff respected their privacy and dignity. Staff told us they would ensure doors were closed and that people were covered when providing personal care. We asked people if they had been involved in developing or reviewing their care plans, and asked if staff had discussed their care plans with them. Two people told us they were not aware of their care plans but did not wish to be. One person said; "No, there's no need [to go through the care plan]. They know exactly what to do." Three relatives we spoke with told us they had been involved in reviewing and updating their family member's care plan. One relative told us; "[The provider] came and talked through the care plan and listened to what we wanted." A second relative said; "We have a care plan in the home and we've had it reviewed regularly."

Good

Is the service responsive?

Our findings

People we spoke with told us that staff turned up for calls on time, or that there were only slight delays, if for instance the traffic was bad or staff were delayed on a previous call. One person said "Oh yes, they are nearly always on time. Just supposing its 6:10 they could be about 10 minutes late. On the whole they're very good." Another person told us; "They turn up on time when they can. The nature of their work means they cannot always guarantee how long the previous call will take. When they come to me, they say if you need more time we will give it to you. They let you know if they're running late." Staff told us they generally felt enough travel time was provided on the rota between calls. However, due to significant road works and the impact this had had on traffic in the area they said this could sometimes cause delays.

Care staff told us there was always a care plan in place prior to them providing people with support. They told us they had opportunity to read care plans and were notified if any changes had been made. One staff member told us when they had been required to support someone they had not worked with before that they had called the office for an overview of this person's needs, as well as checking documentation, such as a task list in their home. Staff told us care plans contained sufficient information to enable them to understand what care and support people needed. One staff member said; "Care plans contain sufficient information. The rest is about building a relationship and allowing scope for individuality." This demonstrated a person-centred approach to care provision.

The provider had undertaken initial assessments of people's needs before they started to use the service. These formed the basis of the care plans and included basic information such as access to the person's house, medical conditions, the safety of the environment, mobility and preferred call times. Task lists had also been produced, which provided staff with an overview of the care and support people required for each call. We saw guidance in relation to the care and support people required recorded in care plans had been completed to varying levels of detail. This was dependent in part, on the size of the care package and the complexity of the support required.

The provider told us reviews of people's care would be conducted when required, based on feedback from care staff, the person or family. There was evidence in some care files of initial assessments having been reviewed and updated when a person's care needs or care package changed. However, there was no evidence of review in other files, which meant we could not be certain if this was as there had been no change to in their needs and preferences, or if it was due to a review not having taken place. The service had recently introduced a new electronic care management system, and we saw staff had started to use this system to record when reviews had taken place. The manager told us this system would flag when a routine review of people's care was required.

We saw there were some records of people's preferences in care plans, such as in relation to the gender of the care staff supporting them and in relation to food and drink preferences where this was part of the support provided. There was some recording of people's social histories in care files, including previous occupation, interests and family members. This would help staff get to know people and provide potential topics of conversation. One staff member told us some people's care plans detailed preferred routines and

times they usually went to bed. They said they were aware of such information but would still always ask and offer people the choice about what they ate or drank or when they supported them to bed.

The provider told us they aimed to provide people with 'holistic care'. They said they did this by recognising and supporting people's social support needs alongside their needs in relation to physical care. They provided an example of supporting a person to access different activities and groups in the community, as well as going with them to a local pub. The majority of the people receiving support from Family Care Solutions were funding their care personally, which meant the service had more flexibility to provide calls of longer duration where such support could be provided. The provider told us they had undertaken calls for two people in the past, which were of 15 minutes duration. However, they said they did not generally provide calls of 15 minutes or less, as they did not fit with the model of care they aimed to provide. They said they had given significant consideration before accepting to undertake 15-minute calls as to whether staff would be able to meet people's needs adequately in this time-frame.

People we spoke with told us they would be confident to raise a complaint if they were unhappy with the service they had received. One person told us; "I've not made a complaint. I would tell them off and go through the boss if I was unhappy." Two people we spoke with told us they had made minor complaints, which had been resolved quickly and to their satisfaction. We found there were no records of any complaints. The provider told us they had never received a formal complaint and that most complaints tended to be minor issues that could be quickly resolved which were not formally recorded. People we spoke with confirmed this was the case. For example, one person said; "I don't think a formal complaint would be required, as if I bring up an issue they sort it. There is a good relationship with family care solutions."

We recommend that the provider reviews procedures in relation to the recording of complaints.

Good

Is the service well-led?

Our findings

Family Care Solutions was a family business. The provider was an individual who had day-to-day responsibility for managing the service. A second manager and a care coordinator, who were both family members, supported the provider in the management of the service. The service had recently recruited a second care coordinator who split their time between the office and providing care.

From our discussions with the provider and manager, and from hearing discussions they had with staff, it was clear they knew the people supported by the service well. The provider told us all the managers got involved in the provision of care, which helped them keep in touch with people using the service. The provider and manager spoke about people with kindness and it was evident from our discussions that there were cases where significant effort had been put into providing people with a quality service. The manager told us; "We are proud of what we have done and how we treat people," and said there had been; "Five years of total commitment to Family Care Solutions." The provider spoke about attending both CQC and sector specific events to help ensure they maintained their knowledge around requirements and good practice.

People using the service and their relatives talked positively about their experience with Family Care Solutions. They told us they were satisfied with the service provided and were always able to get hold of a manager at the office if they wanted to discuss any aspect of their care. Some comments we received included; "I think they are very good. They produce a service that is efficient and nicely done… It's a small organisation providing a local service;" "I've had other care companies before and this is the best. They are everything I'd expect in a care company;" and "Staff at the office are approachable and listen. When I ring to discuss something, I find I'm talking to the boss. They know me and I know them. It's on a personal basis."

One person we spoke with told us; "I've found them good. They employ good people." The provider told us they 'looked after' their staff, which they felt helped them retain a good staff team. The provider told us, and staff confirmed that they were employed on guaranteed hour's contracts and were paid above minimum wage. Staff told us they were happy in their job roles and felt valued for the work they undertook. They told us the management were fair, supportive and approachable. One staff member told us they had recently worked at a different care agency and said; "Family Care Solutions have been really good so far. The management are miles better [than at the previous care agency]. You can hear bad things about staff in care, but this company, I couldn't recommend it enough. The outcome of the work is so much better. I've seen it first-hand."

In the provider information return (PIR) completed by the service in April 2016, the provider had told us annual questionnaires were sent to people using the service to ask about their satisfaction with the care they were receiving. We saw copies of returned questionnaires that the provider had sent out in December 2014, 18 months prior to our inspection. We discussed this with the manager who told us they would be sending out a new questionnaire in the near future. They said this had not been sent in the last 12 months due to prioritising work on getting the new electronic care management system up and running. People we spoke with confirmed they had not been formally contacted recently to ask for their opinion on the service. However, they told us they were happy with the service provided and said either that they had regular

contact with a manager or that they had no need to contact a manager as everything was working well.

The provider told us staff returned records of care such as daily notes and medication administration records (MARs) on a regular basis. They told us there was no determined time for this, however they said, as a minimum staff would do this on a monthly basis. We saw evidence of records from the two months preceding our inspection having been returned. The provider told us they would check daily notes and MARs when they were returned to the office and would initial the sheets to indicate this had been done. We saw the provider had initialled some records; however, one person's MARs and daily notes had not been initialled for April or May. There was evidence that where checks had highlighted shortfalls that action had been taken. For example, we saw that the provider had identified recording errors on MARs and had taken steps to address this.

We asked what other systems the provider had in place to monitor the quality and safety of the service. The provider informed us they carried out regular checks of care plans and staff files, and said these had been done recently. We spoke with one of the care coordinators who confirmed this was the case. They told us they had noted down any issues such as missing documents and had taken actions to rectify any issues. However, no formal record of this had been kept. We saw there was a system in place to record any accidents or incidents that occurred. There were no accident forms in the file from the past 12 months. The provider confirmed there had not been any accidents, including falls within this period. There was no overview, or matrix to indicate when staff had last received supervision and the training matrix did not indicate the training undertaken prior to the new system of training being introduced. The provider told us the new electronic care management system would help monitor provision of supervision as records could be stored on this system. The provider told us they intended to start to focus on formalising quality assurance systems now that the new electronic care management system was in place and with the assistance of the recently recruited second care coordinator.

We recommend the provider reviews and formalises processes in place to monitor the quality and safety of the service provided.

There were no team meetings held for staff, though this is something the provider informed us in their PIR that they were considering introducing. They also spoke about how the new electronic care management system would help improve communication with staff members. For instance, the system allowed staff to access rotas remotely and receive updates via recorded text message. The provider had considered potential issues such as data privacy and security in relation to the system and they informed us the system met international standards in this respect.

The provider had a range of policies and procedures in place, including safeguarding, recruitment, whistleblowing and mental capacity/consent. We noted that these policies were dated 2011 and were based around CQC's old guidance for compliance. This guidance was replaced in April 2015 when the Regulated Activities regulations were updated.

We recommend the provider reviews their policies and procedures to ensure they reflect current guidance and good practice.

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 12 HSCA RA Regulations 2014 Safe care and treatment The provider was not taking reasonably practicable steps to reduce risks in relation to moving and handling. Regulation 12 (1) (2)

Regulated activity	Regulation
Personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed Safe systems of recruitment were not being effectively operated. Regulation 19 (2)