Pure Care Support Limited

Pure HomeCare

Inspection report

19B De Montfort Mews
De Montfort Street
Leicester
Leicestershire
LE1 9GE

Tel: 01162549450
Website: www.purehomecare.co.uk

Date of inspection visit:
13 March 2017

Date of publication:
18 April 2017

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 13 March 2017 and was announced.

Pure HomeCare is registered to provide personal care and support for people living within their own homes. At the time of our inspection there were 72 people using the service. People's packages of care varied dependent upon their needs. There were 69 staff employed.

This was the first inspection of the service since re-registered at this location in April 2015.

Pure HomeCare had a registered manager. 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.

People's safety and welfare was promoted by staff that had received training and understood their role in protecting people from risk. Safety and welfare was further promoted through the assessment and on-going review of potential risks to people. Where risks had been identified measures had been put into place, which included the use of equipment to reduce the likelihood of risk and were recorded within people's records and understood and implemented by staff.

The investment by the provider of I.T. systems was used to promote people's safety, by recognising when staff had arrived at a person's home. Should staff be delayed then an alert was generated which ensured action was taken. The system helped to ensure people were safe and confident that their care would be provided.

Staff upon their recruitment had their application and references validated and were checked as to their suitability to work with people, which enabled the provider to make an informed decision as to their employment. Staff underwent a period of induction and training. Staff were introduced to people whose care and support they would provide. Training provided to staff and their understanding of their role and responsibilities meant people were supported appropriately with all aspects of their care, which included support with their medicines.

People's needs were effectively communicated, recorded and understood by staff that helped to ensure their needs were met. People's care and support needs were electronically stored and staff used mobile devices to record the care and support provided. The IT systems also alerted staff should people not receive the care and support as detailed within the care plan, or when changes to people's needs were made. This helped to ensure people's care was monitored and that appropriate actions were taken to meet people's needs.

Staff understood the importance of seeking people's consent prior to providing care and support. Staff were

aware of people's rights to make decisions and were able to tell us how they encouraged people to express their opinions on their care and support. Staff liaised with health care professionals and kept in contact with people's family members where they had concerns about people's health. People received support with the preparation, cooking and eating of meals where needed to ensure people's nutritional needs were met.

People's records, including their care plans had been developed with the involvement of themselves or their relatives and provided information for staff about the person. The information was used to develop positive and professional relationships when delivering personal care and support, reflective of people's wishes and preferences. People and their relatives in the main spoke positively about the attitude and care of staff, with many stating they received support and care from a consistent group of staff. Where changes to the staff involved in delivering people's care had resulted in concerns being expressed, we found the care manager had taken action to further improve the continuity of care staff and had liaised directly with people or their relatives.

The open and innovative approach adopted by the management team, meant people using the service and their relatives had access to information using a range of methods and systems. This was reflected in people's comments and the information we obtained by speaking to staff members in a range of roles. The provider's commitment to the continual development of the service and its aim to continually improve the quality of care it provided meant the provider continued to invest and identify areas for further development and improvement, which included investment in staff training, career development and the use of technology.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People were protected from abuse because staff had an understanding of what abuse was and their responsibilities to act on concerns.

Risks to people's health and wellbeing had been assessed and measures were in place to ensure staff supported people safely.

There were sufficient numbers of staff available to keep people safe who had the appropriate skills and knowledge. Safe recruitment systems were followed to ensure staff were suitable to work with people who used the service.

People received support with their medicine which was managed safely.

Is the service effective?

Good

The service was effective.

People were supported by staff who had the knowledge and skills to provide their care and who understood the needs of people.

The provider and staff understood their role in promoting people's rights and choices in all aspects of their care and support.

People were provided with support, where required, to meet their dietary requirements.

People were supported by staff who liaised effectively with health care professionals, to promote their health and welfare.

Is the service caring?

Good

The service was caring.

People were supported by a consistent group of staff, who they had developed positive professional relationships with.

People or their representatives were involved in the development of care plans and their views about their care were recorded.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed prior to receiving a service and were regularly reviewed. Staff knew how to support people and took account of people's individual preferences in the delivery of care.

People's concerns and complaints were listened to and acted upon and used to develop the service being provided.

Is the service well-led?

Good

The service was well-led.

The provider had invested in technology to support the development of the business in its commitment to continually look at ways to improve the quality of the service through monitoring.

The provider evidenced a continual commitment in investing in the development of the quality of its care provision, through the support of staff which included opportunities for career development.

Systems for monitoring the quality of the care were in place. A registered manager was in post. They had received positive comments from those using the service, family representatives and social care professionals involved in people's care in relation to the quality of care provided.

Pure HomeCare

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 checked 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 13 March 2017 and was unannounced.

The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the office to meet with us.

The inspection was carried out by an inspector and an expert by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service, the expert by experience had liaised with a range of services in support of people's needs, which included domiciliary care services. The expert by experience contacted people using the service and their family members by telephone to ask them about the service they receive through Pure HomeCare. We sought people experiences and views by contacting ten people who used the service and the relatives of seven people.

We contacted commissioners for social care, responsible for funding some of the people that use the service and asked them for their views.

Before the inspection we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. The provider returned the completed PIR.
We spoke with the registered manager, the care manager, the training manager, a care-co-ordinator, the human resource manager, the client relationship support officer, four members of care staff and a field supervisor.

We looked at the information held about the provider and the service including statutory notifications and enquiries relating to the service. Statutory notifications include information about important events which

the provider is required to send us. We used this information to help us plan this inspection.

During the inspection visit we looked at the care records of six people who used the service. These records included care plans, risk assessments and daily records. We also looked at recruitment and training records for three members of staff. We looked at the provider's systems for monitoring quality, complaints and concerns, minutes of meetings, and a range of policies and procedures.

Good

Is the service safe?

Our findings

We asked people if they felt safe when receiving care and why. People told us, "I do feel safe because they (staff) do know what they are doing; apart from some of the very new ones and then I have to tell them what to do. The carers also knock at my sitting room door after they have let themselves in so that they don't frighten me." And, "I know she (relative) is safe with the carers. I've seen them out with her and they walk with her and hold her hand as they cross the road, and link arms with her."

Staff were trained in safeguarding adults as part of their induction so they knew how to protect people from avoidable harm. Staff we spoke with were knowledgeable about their role and responsibilities in raising concerns with the management team and the role of external agencies. The provider's safeguarding and whistleblowing policies advised staff what to do if they had concerns about the welfare of any of the people who used the service

Assessments were undertaken to assess any risks to people who used the service and to the staff supporting them. These were recorded in people's care plans, and focused on external and internal factors of people's homes. For example, to promote staff's safety external risk assessments identified where staff could park their car, the standard of street lighting and whether there were any other areas of concern in accessing people's property. In some instances a key safe was installed where people were unable to answer their door. A key safe is a secure method of externally storing the keys to a person's property. This helped to ensure people's safety within their homes whilst enabling staff access to the person's home.

Information was held within people's records as to the location of gas, electrical and water installation, which could be accessed in an emergency. One person told us, "I did have a gas fault and the carer was able to get in touch for me and sorted it out which was a great help because I can't always hear very well on the phone." Internal risk assessments looked at the person's home, and whether staff could provide people's care safely. For example, if people had difficulty with mobilising around their home and required equipment, then risk assessments looked at whether there was sufficient space for those using the service and staff to use the equipment safely. Staff received training on the promotion of people's safety, which included how to support people when moving around their home and the use of specialist equipment such as a hoist or stand aid. People's safety was therefore maintained and their comments supported this.

The provider had invested in an I.T. programme. An aspect of the programme was its ability to process and store information through mobile technology. All staff had a mobile device, which upon entering a person's home; they used to scan the bar code on the person's care plan which alerted staff based within the office that the member of staff had arrived at the person's home. If the system was not activated within 10 minutes of the scheduled time then the staff based within the office were alerted and would then contact the staff member to find out if there was a reason for their delay in arriving at the person's home. Staff could then contact the person so that they knew there was a delay but that someone was on their way. If for any reasons staff based within the office did not respond and take action, then an e-mail was sent to alert the care manager. The system enabled the provider to promote people's safety by taking action to ensure staff arrived timely at their home to provide their care.

People spoke to us about the reliability of the service with regards to their safety and referred to recent improvements, whilst others said they did on occasions experience late calls. "They (staff) are usually on time. They are sometimes a little late at night but I complained to the office and they altered it and it's now ok." "They are usually here at the right time. If they are very late the office (staff based at the office) will ring." "They (service) have a system which if they don't log in as having arrived the office phone them. That reassures me." And, "Things have improved over the last six to nine months. They (office based staff) will ring and check the staff are here."

Assessment of people's needs when they initially commenced a service through Pure HomeCare determined the number of staff required to ensure people's needs could be met safely. For example, some people required the support of two staff to assist them in moving from one place to another by the use of equipment, whilst some people needed two staff to support them when their behaviour became challenging. The Provider Information Return (PIR) referred to the computerised rota management system, which was the responsibility of a designated member of staff, the care co-ordinator. The care co-ordinator showed us how the system worked and how its programming meant staff that had the training to meet people's specific needs and staff that had supported the person previously were identified by the system. This helped to ensure people received care from staff that they were familiar with and who could meet their needs.

We looked at staff records and found people's safety was supported by the provider's recruitment processes. Records contained a completed application form, a record of their interview and two written references. A criminal record check had been carried out by the Disclosure and Barring Service (DBS). The DBS checks help employers to make safer recruitment decisions by providing information about a person's criminal record. This meant people could be confident that staff had undergone a robust recruitment process to ensure staff were suitable to work with them.

We spoke with the human resource manager who told us how the recruitment of staff was targeted at geographical areas as people's needs were assessed and referred to the service by commissioners. This assisted the provider in ensuring that there were sufficient staff in place to meet people's needs safely.

People who received support with their medicine spoke positively about the care provided. They told us, "They (staff) always ensure that I take my tablets and there have not been any problems." "They give me my medication. I only take paracetamol and it's all been fine." "I can get my own tablets but they always get me a glass of water and check that I take them." "They get the tablets out for me but I take them myself and they know if I take the tablets." And, "I think [staff name] knows a bit about Parkinson's and the importance of the tablets."

The registered manager and care manager told us staff assisted, prompted and administered medicine to people who required support. The provider had a clear policy and procedure for medicine management. People or their representative signed an agreement, which clearly detailed the role of staff and their responsibility in medicine management. This included information that staff would only administer medicine that was prescribed by a health care professional and had been dispensed by a pharmacist into a monitored dosage system. The administration of people's medicine was recorded by staff on the mobile electronic devices, each medicine prescribed had to be confirmed as being administered. This meant, if for any reasons the system was not updated then the system would alert staff to ensure that all medicine had been administered as prescribed.

People's care plans detailed the medicine the person was taking, why the medicine had been prescribed and potential side effects to be aware of. For some people, the timing of medicine administration was

important to ensure it worked effectively, for example before or after food. This was documented within a person's care plan. For example, 'My [tablets name] need to be taken at 9am, 30 minutes before breakfast.' This information assisted staff in understanding all aspects of people's care, including the promotion of their health, which meant they were able to support people safely.

Good

Is the service effective?

Our findings

People and their relatives shared their views about the knowledge and the competence of staff to meet needs, and how this had a positive impact as they had confidence in the staff and the service being provided. Their comments included "The new manager is gradually introducing specific training for specific clients and this means that I feel safer and can totally relax as they understand my condition." "A hoist has been ordered for my wife, however at the moment with two members of staff we are managing. We are not sure how my wife will respond to the hoist; it may be scary for her. [Staff member's name] knows that. I trust them implicitly and I feel reassured when she is there." And, "Staff know him and are always competent and have his interests at heart. I need to be able to trust them as I go out to work. They have never had to phone me at work because they couldn't deal with something."

The provider was committed to staff development and training, and had a programme of training in place for staff, which included training programmes for staff tailored to meet the needs of individual people. These specifically focused on people with complex needs, who had a range of areas related to their health and wellbeing that they needed support and care with.

The training of staff was overseen by the training manager who had links with organisations, for example Parkinson's UK, who provided specific expertise to ensure that the training provided reflected current guidance. All staff commenced work with a three day induction programme based within the office. Staff new to the field of caring for people were enrolled to undertake The Care Certificate. This is a set of standards for staff that upon completion should provide staff with the necessary skills, knowledge and behaviours to provide good quality care and support. The training manager validated the competence of staff with regards to their theoretical learning.

An aspect of the role of field supervisors was to provide the practical support and guidance for new staff. This included assessing staff competence with the practical side of completing The Care Certificate. Staff received on-going assessment of their competency to perform their role, through observed practice and supervision. This ensured the care and support people received was of the appropriate quality and standard. Newly appointed staff were assigned a 'mentor', who worked alongside them to provide support in person or by telephone. We asked a field supervisor about the mentoring role and they told us they worked with the training manager to ensure staff had the appropriate training and support. They initially met with the new staff, before they were introduced to the people who they would be providing support and care to.

We were told by staff that communication was effective, with support and advice always being available to them by contacting staff based within the office. When the office was closed staff were supported by the field supervisor. Staff provided examples of when they had required support and the support they received was timely and had a positive impact on people's care and welfare. For example, a member of staff had identified a cut to a person's skin. They had contacted the field supervisor and completed an incident form. The field supervisor met the member of staff at the person's home to assess the situation for themselves. A district nurse was contacted who provided the appropriate care.

Staff referred to a system known as 'road runner', this was a quick and effective way to share information. For example, changes to people's needs, such as their medicine or changes made to the staff rota at short notice. Staff told us that the system alerted them through 'beeping' on their mobile devices, which only stopped once they had acknowledged the message. This meant managerial staff and those based in the office knew when staff had received the message and therefore undertaken any action required.

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA and applications must be made to the Court of Protection. We found there to be no one who used the service required such orders.

The registered manager and care manager were aware of the MCA. They informed us that people who received support were able to make decisions about their care or had family members who represented them, which included where people had Power of Attorney in decision making. People's records reflected the decisions they had made about their care and support. For example; where they had declined aspects of personal care or had chosen not to have a meal.

Assessments were undertaken to assess any risks to people with regards to their nutritional intake, which included the risk of people not eating or drinking enough. Care plans provided guidance for staff on how to reduce the risk and promote people's health and welfare. For example, by ensuring staff prepared and cooked meals for people and encouraged them to eat and drink. To encourage people to eat, people's views about their meal preferences had been sought and recorded, which included specific aspects relating to culture or religious practices. For example, 'please encourage me to drink when with me as I forget if it is just left.' And, 'my family will have prepared my meals but I would like you to assist me by ensuring I have washed my hands before and after eating. This is important to me for religious reasons.'

People's records contained the contact details for health care professionals who were involved in their care, which included their doctor. We spoke with people and asked them whether staff had had to contact or liaise with health care professionals on their behalf. "One time I fainted and the carer phoned an ambulance for me and they checked me over. I'm glad she (staff) was there." "They phoned the doctor when I've felt unwell and they were with me until they come."

Good

Is the service caring?

Our findings

We asked staff for their views about the service they provided and its impact on them and the people they cared for and supported. They told us, "Sometimes when we provide care, you can see people are happy that care has been provided." "I like to give my 100% to my clients. I like to go and help and see them smile." In some instances people using the service and their relatives told us about aspects of the service with regards to staff that they were not happy about. We spoke with the care manager about their comments. We found the care manager was aware of the issues we had raised and shared with us the action they had or were taking. The care manager had spoken with the people or their relatives either by telephone, by e-mail or in person. The care manager informed us that once issues had been dealt with people or their relatives would be contacted and made aware of any action being taken.

People reported that they found the staff to be caring, friendly and respectful. People's comments included, "They are all very caring and so patient. [Staff name] is like a friend. We don't spend a lot of time talking as she knows I like to rest but she is here to help me." "The manner of the carers and the attitude is always very good and very cheerful which is lovely for me." And, "They are all so nice. I don't think they would do this job if they weren't nice people. They chat to me about all sorts of things and what I've been doing. They let themselves in with the key they will help me up and they always get me a drink and leave me with a drink."

People's relatives who spoke positively about the service. "They have helped his quality of life because they do things within him which he wouldn't be able to do such as getting some exercise and he enjoys their company." "[Staff name] comes in and get on with it and gets on well with Mum. Mum will say 'oh my friend's coming' and smile. [Staff name] knows a lot about mum and she understands about mum's dementia. She know the things mum can make decisions about such as what she would like to wear or what she wants to eat. She always gives her choice but realises that some decisions are too difficult for her and she talks to me. When they (staff) come to the house they always involve mum in everything and I'm really happy with them." And, "[staff's name] is so good with her. I can hear them chatting as I'm getting ready for work and it's lovely……they go with my daughter's wishes and tell me what they have done afterwards."

As part of the assessment and care planning process, people were encouraged to provide information about their lives. This enabled staff to develop professional and caring relationships with people and provide information so that they could talk with people about their lives and interests.

People's care plans contained information about their specific health needs, which included how this affected them on a day to day basis. This provided staff with an insight as to how people's day to day lives were affected so that they could provide the support and care needed. For example, one person's care plan stated. 'I have arthritis; it is painful and restricts my mobility and flexibility. Making everyday tasks, slow, arduous and physically taxing.' The care plan went onto say, 'I'll need assistance with undressing, dressing, including zips and buttons.' This showed a tailored approach to people's care and support.

The provider had two staff who were dignity champions. A dignity champion is someone who believes that treating an individual with dignity is a basic human right, not something that can be done if there is time.

They believe that care must always be compassionate, person centred with staff willing to do something, no matter how small, to achieve this. This is shared within the service by the training of frontline staff as part of their induction and on- going training. This commitment to the promotion of people's dignity supports the provider's commitment in the delivery of person centred and compassionate care.

People's comments reflected how staff promoted their dignity. One person told us, "They (staff) are all nice people. They did ask me what gender of carer I preferred and I said women and they do occasionally send a man but he only comes for the lunch visit not the morning and he is very friendly." "They all let me make my own decisions myself. They make sure that things are done the way I want."

People's care plans provided guidance for staff on the promotion of their privacy and dignity, through consultation and also by their actions when delivering personal care. For example, one person's care plan had recorded 'after entering my home, please call my name so I know you are here. If you are unable to find me, I maybe in the garden as I have always enjoyed my time in the garden.' And, for another person who required staff to change their bed linen, their care plan stated. 'My clean bedding is in the cupboard above the wardrobe.' This meant staff did not have search for the person's bed linen, thus promoting the person's privacy.

The provider had in place a 'service agreement', which provided information as to how data held about people was stored and used. That helped to assure people that information was held in accordance with the data protection act. People's records we looked at contained a 'service agreement', which had been signed by the person or their representative, which included information on data protection.

Good

Is the service responsive?

Our findings

People had an initial assessment of their needs which in some instances was carried out be a social worker where their care package was funded. Staff employed by the provider undertook an assessment of people's needs by visiting them within their own home or their current place of residence, to ensure the service could provide the support and care they required.

Assessments were used to develop care plans, which were person centred. 'Person centred' is a way of working which focuses the actions of staff on the outcomes and well-being of the person receiving the service. Care plans detailed how staff made sure people were appropriately cared for and we looked at how this was documented. For example, care plans instructed staff to ensure drinks and snacks were left close by so the person could reach them. Whilst in some instances instructed staff in the promotion of people's independence or socialisation. For example, by encouraging people to perform household chores and talk with them about topics of interest, or in accessing the wider community for shopping or recreational pursuits.

Care plans were regularly reviewed; the frequency of review being dependent upon the needs of people. Where people's needs had changed, commissioners funding people's care were informed. Records showed how people's care plans had been updated to reflect people's changing needs. One person told us, "I have recently had my hip replaced and so we needed a temporary slight increase in the care package which they were able to do. They are quite flexible." "Once a year they come out and check in the folder and go through the plan. I'm not sure whether they still write in the folder. To be honest I don't check it as we communicate closely."
A relative told us, "As his needs have changed they have adapted to his needs and changed the care plan accordingly. They came out last week to go through it with us and they always make sure they include us both and respect our wishes." A second relative told us, "We do have a copy of the care plan at home and we are very happy with the service."

The provider had installed an I.T. programme, to which all staff had access. Staff supporting and caring for people within their own homes had access to the system at all times, through mobile technology. This enabled them to view people's care plans and record and enter information into the system to evidence the person's care and support had been provided as detailed within their care plan. One relative told us, "The electronic records system really suits me although it must be hard for some people. I can utilise it to see rotas and photos of staff and it tells me about staff training and any spots checks done. It's easy for us and it would be useful for anyone with family out of the area who can look to see what's happening." A second person told us, "They (staff) have a phone with all the details on and they check in before they go and it relays itself back to the office." This showed people were aware of the information held about them which they contributed to and understood how staff used accessed the system to reflect their care and support they received.

The role of the field supervisor was to provide support to staff who directly delivered care and support and who were available outside of normal office hours. We spoke with them about the role and its impact on

people. They told us where people contacted them to cancel their visit, or change the times of their visit; they were able to inform staff so that people received the care and support they needed. They also provided information to staff when they were notified of changes from other agencies, for example when someone was discharged from hospital to their home, to ensure staff were aware of specific information needed to provide good quality care and support.

The field supervisor told us in a majority of instances people using the service developed positive working relationships with staff, however when this does not happen, people's views were listened to and were provided with different staff to meet their needs, where this was practicable. This was confirmed by comments we received from people, and their relatives. The registered manager and care manager told us of their commitment to provide each person with a core group of consistent staff whilst introducing new staff to people so that they can provide people's care when other staff were absent from work.

We found there to be varied views about the consistency of staff in providing people's care. "I'm quite happy with the carers. We have our ups and downs at holiday times (when people's regular care staff were on leave) the rest of the time I tend to see the same people. They always introduce new people to me but it's hard for me as I have to explain everything to them." "We always get the same carer and she is fantastic." "They do change the carers quite a lot at the moment I do have one more regular person who is lovely. I would prefer more consistency as it's hard to get used to people." "One of the things they tend to do is chop the carers around a bit. We have one who is very good and we have them about 85% of the time but the second carer changes a lot." And, "We are quite happy with the service. We get regular carers and this really helps my husband as he got used to them and they to him."

We spoke with the care manager and shared with them the views of people and their relatives where they had raised concerns about a frequent change in staff providing their care. In all instances the care manager was aware of the specific issues and had liaised with people to discuss their concerns, either by telephone, e-mail or in person. Action was being taken, which included the employment of new staff and introducing existing staff to people.

People we spoke with could not recall having made an official complaint but everybody stated that they would be happy to do so if necessary. Several people had reported concerns to the managers and reported that action was taken regarding their concerns. People we spoke with told us, "When I raise concerns they do listen and action things. They are striving to improve and they involve me in all decisions." Whilst people's relatives said, "I'd feel very happy to complain if I needed to."

As part of the provider's commitment to listen and respond to people who use the service, a role known as client relationship support had been developed. We spoke with the member of staff about their role. They told us they provided support to people with the view that initial concerns if managed well would ensure people received a quick and responsive approach, before their concerns escalated. As part of their role they visited people in their home to discuss issues with view to a resolution. This showed a pro-active approach by the provider in listening to people's views and taking action.

All concerns were recorded, investigated and the outcome including any lessons learnt were noted. We saw records which evidenced the action taken and included risk assessments following a specific incident and how this was communicated to staff, to promote everyone's safety and well-being.

The PIR stated the service had received two complaints within the last 12 months. These complaints were in relation to terminology used within people's records and concerns with regards to the medication policy. Both complaints were investigated and measures taken to address the concerns.

The PIR advised the service had received 13 compliments within the last 12 months, the provider had analysed the themes from these compliments. They found they reflected the level of care being provided, with specific reference to the suitability of staff in providing care and support to people, which had led to positive professional relationships being made.

Good

Is the service well-led?

Our findings

We spoke with people who used the service and their relatives about their experiences when contacting staff based within the office, and whether their views about the service being provided were sought. Whilst the comments were mixed, they did reflect the recent improvements which included, "I'm generally happy with the people in the office." "I don't think they communicate that well with each other in the office. They are all pleasant but you have to repeat yourself so often." "[Staff name] came out last week to see how things are going and we told her that we are pleased." "I've had three other care companies and these are the best and they are keeping staff more now." "The new manager is great. Something has really improved."

We found the provider, registered manager and care manager had been forward thinking in their development of the service, and regularly reviewed the service being provided. They had introduced new systems which had had a positive impact on the delivery of the service for people and the staff employed.

The care manager wrote to people when they commenced a service with Pure Homecare. The letter in addition to welcoming people provided the names of staff based within the office and information as to their key areas of responsibility. The letter also referred to the 'client portal' and the out of hour's team. An introductory booklet was sent out, which provided key information about the service it provided, this included information on how to access the client portal and included their unique identifier codes and password. (A client portal is an electronic gateway to a collection of digital files, services, and information, accessible over the internet.)

A computer package installed on the provider's I.T. system, meant people using the service or their relatives had access to information via the client portal. The information included a copy of the staff rota, which meant people knew which staff would be providing their care and included a photograph of the member of staff and an overview of their training and supervision. The portal also provided information as to monthly invoices for care, where people funded their own care.

The provider had installed an online care management application onto their I.T. system. This provided access to people's care plans and daily notes completed by staff via a 'mobile app', this information could be accessed by authorised parties, which included staff, people using the service and their relatives as well as health and social care professionals involved in people's care. This demonstrated the provider's commitment to being open and transparent by ensuring people had access to their records. The registered manager and care manager had sent a letter to people about the new system. The letter contained information about the system, which included the reasons for its introduction, which was to provide a timelier and immediate response to people's changing needs. The system provided alerts, which were responded to, should staff not deliver people's care and support as detailed within their care plan at the time allocated. The letter in addition provided reassurance to people as to confidentiality and the provider's commitment to its obligations under data protection.

The provider supported staff in a range of ways, which included, a staff handbook which included key policies and procedures. Staff had ongoing training, supervision, assessments of competency to perform

their work, team meetings and the line management structure which provided an on-call service for staff to access out of office hours. Staff spoke positively about the support they received.

Team meetings were regularly held which enabled staff based within the office to discuss key aspects of the service. This included staff recruitment, training and on-going development. In addition specific issues relating to the service were shared with a view to looking at how things could be improved. For example, by ensuring people were kept up to date of any changes where staff providing their care and support had to be changed at short notice. Meetings were also used as an opportunity to discuss specific aspects related to people's care along with new clients who had been referred to the service. Staffing issues, which included recruitment, staff pay and retention of staff, were also discussed.

As part of the provider's commitment to providing a good quality service all contact with staff based within the office was recorded and an enquiry opened, a summary of the information was made and the enquiry assigned to the correct person for a response. To enable and facilitate office based staff to provide a response, protected time was set aside during the week for staff to respond to issues raised. The way in which information was received, meant the I.T. system required an outcome and response before the enquiry could be closed. Roles had been created to support the provider in the delivery of its services; these included the client relationship support role and care co-ordinator. Whilst in the office we heard the care co-ordinator speak with the relatives of someone who was awaiting discharge from hospital, they informed the person when the services of Pure HomeCare would commence and the staff who would be arriving at the person's home.

The provider had a clear management structure in place which supported staff that provided the care and support to people in their own homes. The managerial structure and staff based within the office had key areas of responsibility, which were overseen by the care manager. Regular meetings took place between office based staff and the care manager, where staffs individual performance was assessed against key performance indicators. This ensured all staff had agreed targets of achievement which were monitored to enable the care manager to monitor the impact of the service on the people they supported and cared for.

A range of roles had been created to provide a career structure for staff who wished to develop and progress in their career. The role of the field supervisor was to provide support to staff who directly delivered care and support and who were available outside of normal office hours. We spoke with a field supervisor, who told us about their role and its impact on people using the service and staff. They told us that they provided staff with on-going training specific to people's individual needs and worked alongside staff as they introduced them to new people in their homes. They spoke of the weekly meeting they had with the other field supervisor and the care manager, which enabled them share information so that they could provide a seamless service of support. Part of the role was to liaise with health and social care professionals to ensure people's needs could be met, which included visiting people new to the service to find out if the service could and continued to meet their needs

Staff that in the view of the registered manager and care manager worked well and who had also received positive feedback and comments from people using the service and their relatives were recognised for their work. Staff in these circumstances were awarded the title of 'elite caregivers' in recognition of going above and beyond their role. We spoke with a member of staff who had been awarded the title of elite caregiver and asked them what attaining the new role meant. They told us part of their role was to trial new systems, which had included the online care management programme. In addition they worked with people who had expressed concerns about some aspects of their care, particularly for those people with complex packages of care, to bring about improvement and strengthen the professional working relationship with the staff of the service.

Commissioners informed us of the number of people who they commissioned a service for and said they had no concerns about the service being provided by Pure HomeCare. Any concerns historically made had been managed well be the provider.

The PIR included planned improvements the provider looked to implement over the next 12 months to further develop the service. These included the recruitment of additional staff in new roles and the expansion of existing roles. These reflected the provider's commitment to staff development by enabling field supervisors to attain a qualification to enhance the quality of vocational assessments undertaken by them, on new staff undertaking The Care Certificate.

An aspect of further development around people's care and support was to focus on palliative and end of life care planning. We found the provider had already accessed training with organisations that specialise in this area care.

The PIR detailed the planned implementation for annual surveys to those using the service, their relatives and staff. This would provide an opportunity for the provider to receive feedback on the service.

The PIR referred to the recognition the service had received with regards to its good practice within the last 12 months. These included the innovation women's award in business 2016, the East Midlands Chamber of Commerce Employer and Apprentice of the Year 2016 finalist. The PIR asked how the provider, registered manager and other staff kept up to date with good practice. They referred to their membership of the United Kingdom Healthcare Association, its links with ACAS and Croner who advise of developments affecting good practice and how it relates to human resources. The training manager took responsibility for ensuring changes to practice were implemented into staff training.

We found the registered manager, care manager and all the staff we spoke with to be enthusiastic and committed to providing a good quality service to people within their homes, and spoke of their wish to continually improve the service.