Interserve Healthcare Limited

Interserve Healthcare - Leicester

Inspection report

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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?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 6 September 2016 and was announced. We gave the provider 48 hours' notice of our visit because the location provides domiciliary care and we needed to make sure there would be someone in the office at the time of our visit.

Interserve Healthcare - Leicester is registered with the Care Quality Commission to provide personal care to people who wish to remain independent in their own homes. The agency provides services throughout Leicester and surrounding areas and provides for people with complex healthcare and social care needs. At the time of our inspection there were 10 people using the service who were supported by 73 staff.

There was a registered manager in post. 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.

This was our first inspection of the service since they registered with us.

There were good systems and processes in place to keep people safe. Assessments of risk had been undertaken and there were clear instructions for staff on what action to take in order to mitigate them. Staff knew how to recognise the potential signs of abuse and what action to take to keep people safe.

The provider had arrangements in place for the safe administration of medicines. Staff supported people to manage their medicines safely.

People, their relatives and staff felt there had been instances where there were not enough staff through rota errors or unavailability of staff to cover at short-notice. The registered manager had recently recruited more staff to ensure there were always enough staff to meet people's needs as detailed in their care plans. The registered manager followed the provider's safe recruitment practices. This helped to ensure people were cared for by staff who were suitable for the role.

Staff usually arrived on time and stayed for the time allocated. People were cared for by suitably trained staff which helped to keep them safe and meet their needs. Staff understood people's needs and complex health conditions.

Staff understood the relevant requirements of the Mental Capacity Act (2005) and how it applied to people in their care. People's individuality was at the centre of how their care was delivered. They were fully involved in making decisions about their care.

Staff worked with both internal and external healthcare professionals to obtain specialist advice and support about people's care. Staff supported people to manage their complex health conditions, including

nutrition and hydration and general health and well-being.

People's care plans were person centred, detailed and written in a way that described their individual care and support needs in detail. These were reviewed and changes made where required. This meant that everyone was clear about how people were to be supported and their personal objectives met. People using the service and those who were important to them were actively involved in deciding how they wanted their care and support to be delivered.

The provider had a complaints policy which provided people and their relatives with clear information about how to raise any concerns and how they would be managed. People and their relatives confirmed they felt comfortable to raise concerns and complaints to the provider.

People, their relatives and staff had low confidence in the communication and consistency of the management team on a day-to-day basis. People told us they had not been empowered to share their views of the service although they did have opportunity to feedback on their care individually. People and relatives had little contact or opportunity to discuss concerns with the registered manager. We found the registered manager and provider had systems in place to monitor the quality of care. These included audits of key aspects of the service and spot checks of staff working practices. However, we found that audits and observations of working practices were not consistently carried out to ensure staff were providing quality care. Staff we spoke with did not feel they received the consistent supervision and support they needed to develop within their role. Further improvements were needed to ensure outcomes of audits were actioned in a timely way.

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.

There were processes in place to ensure people were protected from the risk of abuse and staff were aware of safeguarding and whistleblowing procedures. Assessments were undertaken of risks to people who used the service and staff. We saw that action was taken in response to incidents and accidents to maintain the safety of people and staff. People were supported to receive their medicines safely.

Is the service effective?

Good

The service was effective.

Staff received specialised and general training and development to enable them to be effective in their roles. Staff were supported through spot checks and telephone calls with the office. The provider ensured people's best interests were managed and staff worked within the principles of the Mental Capacity Act (2005). People's needs were regularly assessed and referrals made to other health professionals when required to ensure their health and well-being needs were met.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring and friendly. Staff knew the people they were caring for including their personal preferences, likes and dislikes.People's privacy and dignity were respected. People were involved in making decisions about how they wanted their care to be provided.

Is the service responsive?

Good

The service was responsive.

Assessments were undertaken and care plans developed to identify people's care and support needs. Staff were aware of people's preferences and how best to meet those needs. There was system in place to manage complaints and concerns. People

felt comfortable in raising concerns and complaints with the registered manager.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

People, their relatives and staff did not always feel confident in the day-to-day management of the service. People and their relatives felt that improvement was needed in the quality of communication from the management team. People and their relatives did not feel empowered to share their views about the service. There were systems in place to monitor and assess the quality of care people although these were not consistently applied.

Interserve Healthcare - Leicester

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 6 September 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that people would be available to talk with us.

The inspection team consisted of two inspectors 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.

Before the inspection we reviewed all the information we held about the service. Prior to the inspection, the provider had 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 also reviewed notifications that we had received from the service about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law. We contacted local authority and health services commissioners who funded some of the people using the service to gain their views about the service. Commissioners told us they had no concerns about the service and people's care reviews were up to date.

During our inspection we spoke with two people and four relatives of people who used the service, four care staff, one clinical lead and the registered manager. We also observed staff working in the office dealing with issues.

We reviewed a range of records about people's care and how the service was managed. These included the

care records for three people, three staff recruitment and training records, quality assurance audits, incidents reports, complaints and records relating to the management of the service. We also spoke with one health and social care professional after the inspection to gain their views of the service.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. One person said, "I feel safe because I think the training is very good. Staff know what they are doing." A relative told us, "I feel that my family member is in good, safe hands. They (staff) have all been properly trained, for example in using the hoist and the wheelchair. Staff all seem confident with the equipment."

We found people were protected from risks associated with their care because the registered manager had undertaken risk assessments which provided guidance and support for staff to keep people safe. Risk assessments identified the level of risks and the measures taken to minimise risk. Risk assessments included areas relating to the environment, for example potential hazards around people's homes, as well as those relating to people health conditions. For example, risks from skin pressure damage, risks of deterioration of a medical condition or use of equipment such as a hoist to mobilise or a mechanical ventilator which helps people to breathe. Staff could tell us the measures required to maintain safety for people in their own homes. One staff member told us, "I look after one person who relies on me to ensure their spine is correctly aligned in bed and the bed rails are up to ensure they are safe and comfortable in bed." Another staff member told us they followed a person's risk assessment by making sure they always took the person's emergency first aid kit whenever they went out of the house. This showed staff had the guidance and support they needed to keep people safe.

People were protected from the risk of abuse because staff understood how to identify and report it. Staff had access to guidance to help them identify abuse and respond in line with the provider's policy and procedures if it occurred. Staff told us they had receiving training in keeping people safe from abuse and this was confirmed in the staff training records. One staff member told us, "I am confident I would know what to do if I suspected abuse was taking place. I would document and report it. If I felt that the registered manager was not taking my concerns seriously, I would contact social services or the Care Quality Commission." Another staff member told us they were confident in the safeguarding and whistleblowing procedures and would have no hesitation in reporting concerns if they suspected someone was being abused. This meant staff were provided with training and information to enable them to protect people from the risk of abuse.

Staffing levels were determined by the number of people using the service and their needs. However, one person told us, "There have been times, probably two or three, where they (staff) haven't turned up. One relative told us they did not always feel their family member was kept as safe as possible because there were not always enough staff to meet their family member's needs and staff sometimes worked excessively long shifts. They told us there had been a few occasions in the past when staff had not turned up leaving them to manage the care by themselves. One member of staff told us, "There are usually enough staff but there have been some occasions where the office has made an error in the rota which has meant there has not been enough staff and we have had to wait for staff to come in." Another staff member told us there were always enough staff and they had not experienced concerns regarding staffing levels. We looked at the electronic rotas and saw there were sufficient numbers of staff employed to ensure visits were covered and to keep people safe. We discussed staff levels and the staff's concerns with the registered manager who told us they had recently recruited staff for the service to provide consistent care and cover at short notice. They told us

they would meet with the office staff and identify improvements to ensure there were no further errors in staffing rotas.

The provider had robust recruitment procedures to ensure that only suitable staff were employed. Staff recruitment files showed that the registered manager had followed recruitment procedures and staff had completed a full explanation as to their employment history on application forms. We saw that the provider undertook checks before staff began working for the service which included proof of identity, employment references and a check with 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 and whether they are barred from working with vulnerable adults.

The provider had procedures in place to ensure people received medicines as they had been prescribed. People and their relatives felt staff supported them to manage their medicines safely. One relative told us, "They (staff) do the medication and there have never been any problems. They use the Medication Administration Record (MAR) charts." Another relative told us, "They (staff) give my family member medication from a dosset box and they contact the GP surgery and chemist and help us sort out the medication. They are very proactive in that way."

Staff who we spoke with confirmed they had undertaken training in administering medicines and were able to describe how they supported people and the records they completed, including MAR charts. People's care plans included details of their medicines, any allergies they may experience and the level of support they needed to take their medicines. Audits on MAR charts were undertaken on a regular basis to ensure they had been correctly completed. This meant staff had the skills and knowledge to support people to manage their medicines safely.

The provider had a policy in place to promote good infection control by staff. Some people who were supported by staff had complex health conditions making good infection control especially important. The clinical lead told us they ensured staff had continual access to appropriate personal protective equipment (PPE) such as disposable gloves and aprons. One person told us, "They (staff) are always very good at washing hands and wearing gloves and are clean and tidy." A relative told us, "The agency makes sure there are plenty of gloves and staff always wear them when helping my family member." Risk assessments included guidance for staff to follow on the correct use and disposal of PPE and training records confirmed staff had undertaken training on infection control procedures. This showed the provider had considered infection control issues in people's homes and had taken action to minimise their risks when required.

The provider took steps to ensure accidents and incidents involving people using the service and staff were minimised. The registered manager told us that these occurrences were not frequent but when they did occur an analysis of the circumstances was carried out to see if there were any trends or patterns. We looked at records of incidents and accidents and saw that incidents has been logged on internal systems and followed up to identify the cause of the accident or incident. Outcomes were clearly detailed in terms of input from external agencies and action taken to reduce the level of risk which included a review of risk assessments. For example, the registered manager monitored all medicine errors to identify if staff required re-training. The registered manager told us that serious incidents were escalated through the provider's reporting procedures to identify learning points for the whole group.

Good

Is the service effective?

Our findings

People and relatives we spoke with were confident in the care and support they received from the provider and staff. One person told us, "The staff know me so well and they notice if I'm not well and ask if I need the doctor. I have a brilliant team of staff." A relative told us that their family member had complex needs and could be challenging to support. They told us they felt staff were very good and spoke positively of staff who had recently started working for the service as being comfortable in responding to their family member's changing needs.

Staff received induction and regular training. We spoke with staff about their experience of induction. One staff member told us, "I completed an on-line induction of training modules such as communication, safeguarding and patient care. I also completed shadow shifts, working alongside experienced staff where I could observe how they supported people and learn about people's needs." Another staff member told us, "I completed my induction and was signed off by a senior staff member through an observation of my practice."

We looked at staff training records and saw that staff undertook a range of training to enable them to be effective in their role. This included training that was essential for staff in their roles, such as manual handling and administering medicines and specialist courses included spinal alignment and tracheostomy care. This was important to support people who required staff to ensure their spine was in the correct position and equipment to help them breathe was maintained and used correctly. Training was provided through a combination of on-line learning, face-to-face training and specialist training, for example, staff working alongside hospital staff. Some of the specialist courses were carried out by nurses, employed by the provider, who also gave on-going support and oversight of people's care. The provider kept a record of staff training through a training matrix which showed which training each staff member had undertaken and when it was due to be refreshed. We saw some gaps in training that needed to be refreshed for some staff members. When we raised this with the registered manager, they told us this was due to staff shift patterns and training would be re-arranged for the next session.

Staff were generally positive about their training. One staff member told us, "My training is about the right amount for what I need to do in my job. The training gave me confidence to support people who have very complex health conditions." Another staff member said, "I think the training is fantastic. The clinical lead does the medicine training which made me feel comfortable to support people with their medicines. The specialist training, such as spinal alignment was really good and gave me a lot of knowledge." Another staff member explained how they had worked alongside other health professionals to learn about the specific needs of a person living with a complex health condition. This meant people were supported by staff who had the skills and knowledge to provide effective care.

Staff gave mixed feedback on the level of support and supervision they received from senior staff and nurses. One staff member told us, "I don't feel I receive a lot of support. The only contact I have from managers is if I go into the office or we talk on the telephone for updates or the manager sends out an email. I feel there is room for improvement." Another staff member said, "I haven't had a supervision or spot check.

I don't have much contact with the office; I tend to speak to other, more experienced staff for support. I haven't seen the clinical lead for some time." Another staff member told us, "Managers provide me with support if I am struggling. I can telephone the office and explain the problem and they will provide support and advice when it's needed."

We saw that the registered manager arranged for spot checks to be carried out around every three months. Records showed that, where spot checks had been undertaken, staff had been provided with feedback following spot checks to support their development. We saw that managers had undertaken competency observations for staff in areas such as general and clinical care. We discussed staff feedback with the registered manager who told us they would improve the level of communication and support to staff. Following our inspection, the registered manager sent us evidence which showed how they had communicated to all staff informing them of new processes that would improve communication between managers and staff and ensure staff received the support they felt they needed.

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 Act.

We asked staff about issues of consent and about their understanding of the MCA. The spoke we spoke with told us they had undertaken training in this area. One staff member told us, "The people I support can communicate very well. I always respect their choices and decisions. They tell me what they want me to do." Another staff member was able to describe how a person used non-verbal communication to indicate that they were not happy. They told us they looked out for this and respected the person's choice to decline assistance or changed the way they were providing support to the person."

People's care records showed that the provider has assessed people's mental capacity to consent to their care, including consent to the use of specialist equipment such as hoists. Mental capacity assessments included the person's right to decline care and how the person was able to communicate their consent to staff. We found that mental capacity assessments did not always detail the decisions people were able to make and the support they needed to help them to make specific decisions. This was particularly important where people's mental capacity changed from day-to-day. The registered manager told us they would review their mental capacity assessments to ensure people's legal rights were protected in line with the MCA.

People and their relatives confirmed that staff were supportive in meeting people's healthcare needs. One relative told us, "Once when my family member was quite confused and seeing things, staff said we should get the doctor to see whether there was an infection which really helped. Staff do notice things and make suggestions." This showed that staff were effective in their role in supporting people to maintain their health and well-being.

Care records we saw showed that staff made sure people's health care needs were met. Where appropriate the registered manager co-ordinated and maintained consistent access with community healthcare professionals or supported people to attend regular appointments. This ensured people had the advice and treatment they needed. This included contact with general and specialist doctors, dentists, specialist trained nurses and occupational therapists. We saw records which showed how staff contacted relevant health professionals if they had concerns over people's healthcare needs. People's care plans included an

assessment of the person's nutritional needs. Where people received nutrition through a peg feed [a feeding tube], there was clear guidance for staff to follow to enable the person to receive the nutrition they needed.

Good

Is the service caring?

Our findings

People and their relatives told us staff were caring and listened to their opinions and choices. One person told us, "I've got good carers. They know me and my family. They treat me with care and gentleness." A relative told us, "They (staff) do seem to respect my family member and talk to them with kindness." Another relative told us, "The staff are fantastic and have taken so much pressure off the family's shoulders. They know my family member so well." One relative gave us an example of how staff had taught their family member to box to help strengthen their arms. The relative was able to describe how staff spent quality time with the person and made sure there was fun in each day which was important to the person.

People's care records we looked at showed how they wished to be cared for. Their individual choices, preferences and decisions about their care were recorded and used to inform their care. People and their relatives confirmed they had been involved in deciding how they wanted their care to be provided. One relative told us, "I feel that we were included when the care package was put together and all my family member's complex needs included." Another relative told us, "We are very involved with the care and get to say what we want and how we want it."

Staff we spoke with demonstrated that they were knowledgeable about the people they supported and were able to explain people preferences, likes and dislikes. Staff spoke positively about the people they supported and respected people's right to privacy and dignity within their own homes. One staff member told us, "I always make sure the bedroom door is closed when I am supporting a person with personal care to ensure they have their privacy." Another staff member told us how a person needed two staff to support them with some of their personal care needs. They told us they always made sure the person was covered and whilst one staff member was providing support with personal care, the other staff member would move away if they were not required so the person didn't feel intimidated.

People and relatives told us there had been a number of staff changes recently which meant that people were not always able to receive care from a consistent group of staff. One relative told us, "There have been quite a few staff changes and it has been a bit unsettling. Staff have left and lots of new staff have come. They (registered manager) has tried to match staff who have a similar cultural background as my family member. Finding suitable local staff has been difficult so we find staff come from around the country. The constant changes in staff is the most difficult thing to cope with." Another relative told us, "Staff have to spend time building a relationship with my family member. We have so many different staff it's very hard." The registered manager told us they had responded to people's concerns by recently recruiting additional staff to the service so they were no longer relying on staff from other branches to provide temporary cover. They told us this would improve the consistency in the care that people received.

People and their relatives confirmed they received an information pack from the registered manager as part of the initial assessment. We looked at the service user guide which provided people with information on what they could expect from the service, frequently asked questions and key internal contacts. The guide also included useful contact numbers for external agencies, such as local authorities. This meant people were provided with information to support them to make decisions before they began using the service.

Good

Is the service responsive?

Our findings

We spoke with staff and the registered manager who told us everyone who was supported by the service had a 'person centred' care plan. 'Person centred' is a way of working which focuses the actions of staff and the organisation on the outcomes and well-being of the person receiving the service. They described to us how staff made sure people were properly cared for and we looked at how this was written in their care plans.

All the people who used the service had care plans in place. These were developed following an assessment of each person's needs and, where appropriate, a consultation with everyone who had a role in the person's life. People were supported by staff to make decisions about how they would best like their care and lifestyle needs to be met. These decisions formed the basis of a formal agreement between the provider and the person using the service.

We looked at the care records of three people who used the service to see how their needs were to be met. We saw each person's needs had been assessed and plans of care written to describe how each area of need was to be supported. Some people had very complex health needs and their support needed to be extensive and detailed. The care records we looked provided suitably detailed information about each person's health condition. We looked at examples of how people's needs were to be met. For instance, one person's care plan recorded that they needed support to re-position every four hours to reduce the risk of skin pressure damage. We saw there was sufficient guidance in the care plan to enable staff to understand how the person preferred to be supported, what equipment was needed and how it should be used. Guidelines also included how staff should respond in the event that equipment failed or there was a change in the person's health condition. This meant staff were provided with enough information to provide responsive care to people.

People's care plans included a document called 'All about me'. This recorded how a person liked to be introduced to new people, how they communicated, their likes and dislikes and preferences for how they wanted their care to be provided. People and their relatives told us the service was responsive to their needs although some people felt their care was not reviewed in a timely way. One person told us, "They (staff) always write everything down really well. They provide care that meet's my needs. However the care plan is not up to date." One relative told us, "If there are changes they (managers) make an appointment and review the care plan." Another relative told us, "They (managers) haven't suggested a review of the care. We have been using the service for a short while. I have asked for an additional visit and they (managers) have managed to provide it. Through the summer, staff did do an extra day which was important to my family member." The registered manager told us and records confirmed that people's care had been reviewed annually. They told us that in the event of any change in people's needs, a full review of care would be arranged and care plans updated accordingly.

The service protected people from the risks of social isolation and recognised the importance of social contact and companionship. People were encouraged to maintain and develop relationships, hobbies and interests. Staff were proactive and made sure people were supported to keep relationships that mattered to them, such as family, community and other social links. For example, records showed that one person was

supported to pursue social interests through staff companionship whilst another person was supported to maintain their interests in animals and shopping. Staff we spoke with were able to describe how they supported people to continue links with friends and go out into the local community.

We checked complaints records. This showed that procedures were in place and could be followed if complaints were made. We saw the provider's complaints policy and the registered manager, when asked, could explain the process in detail. The policy provided people and their relatives with clear information about how to raise any concerns and how they would be managed.

People and their relatives told us they felt confident to raise concerns with the registered manager and staff. One person told us, "I do know about the complaints policy but I try to sort things out informally in the first place." A relative told us, "There was an issue once which I raised with the office and they respond and resolved my concerns immediately." Another relative told us, "I'm fairly happy with the service and if there are any problems I can phone up and they (managers) always get back to me." We saw evidence of individual complaints and the logged resolution for them. This identified action undertaken by the provider, for example, a review of staff to ensure staff were compatible with the person's preferences. This showed the provider was using complaints as part of driving improvement within the service.

Requires Improvement

Is the service well-led?

Our findings

People, relatives and staff we spoke with shared mixed views on the management of the service. One person told us, "The care staff are fantastic. The main problem is the office staff. They don't communicate with me or with each other. For example, if there is a change in staff they don't always communicate this to me which impacts on my plans. The team in the office need to work together and stop pulling in different directions." A relative told us, "They are not proactive in the office. I am constantly having to chase them." Another relative said, "The office is open and you can call them. I have a named person at the office to speak with. They don't always get back to me as quickly as I would need them to."

Staff we spoke with also provided us with mixed views on the management of the service. Whilst one member of staff felt the service was well-led and had no concerns, other staff we spoke with described the impact that inconsistent communication between managers and staff had on their work. One staff member did not know who the registered manager was. Another staff member told us they did not contact the registered manager as they needed the clinical knowledge of the clinical lead to support them in their role and felt this was lacking from the registered manager. Another staff member felt the service was at times dis-organised in terms of getting resources to staff, such as forms and supplies and in managing staffing rotas. Staff we spoke with felt they did not receive the level of supervision they felt they needed from the registered manager or line managers. This meant that staff did not always feel they received the support they needed or the motivation to develop within their role.

The service had a registered manager in post. They were supported in the day to day running of the service by the clinical lead, branch consultants and office administrator. We discussed people's feedback on the management of the service with the registered manager. They assured us they would use our feedback to make improvements in communication between management, staff and people who used the service to address their concerns. The registered manager provided us with information following our inspection to demonstrate they had acknowledged staff concerns and were implementing new processes to improve communication within the service.

The registered manager told us people had the opportunity to share their views about the service through satisfaction surveys. They told us these were managed by the provider. Information was collated centrally and used to produce an action plan for the service to identify where improvements were required. However, people we spoke with and their relatives told us they had not always been asked for their views about the service completing satisfaction surveys. They did tell us they were able to share their views through telephone conversations with the office but felt that these were not always listened to. For example, people and their relatives told us they had shared their concerns about missed calls and inconsistency in staff with the office but had not received any contact from the registered manager to acknowledge their concerns. They told us the registered manager had little contact or discussion with them about any improvements they planned to make to address people's concerns and felt the registered manager was not aware of day-to-day issues within the service.

Staff were provided with opportunities to feedback about people's care. Staff were supported to attend peer

review meetings which provided an opportunity for staff to meet to discuss care and share information about the person they were delivering care to. Staff were also able to forward suggestions on ways to improve the service. For instance, staff had recently requested additional training to support them in their roles. The registered manager told us they had purchased the training through e-learning so that staff could complete the training as and when they could. The registered manager kept staff informed of changes and updates within the service through a newsletter which was emailed out to all staff.

The provider had systems in place to monitor key areas of the service. For instance, information including complaints, accidents and incidents was collated and entered onto the providers electronic monitoring system. This information was used to compile key performance information and compare trends within the service and with other services run by the provider organisation. For example, the number of accidents that a person experienced per month. This meant that any unexpected changes could be identified and analysed and actions taken to reduce the likelihood of them happening again.

The service conducted a variety of internal audits such as medicines audit and an audit of staff training. The service used the information gathered from its internal audits and audits undertaken by a representative of the provider to make improvements to its procedures to improve the quality of care people received. For example, a review of medicine audits had resulted in the registered manager and clinical lead arranging a meeting with the local pharmacist to discuss improvements in dispensing medicines and paperwork. We saw that the audit of staff training had identified which staff required their training refreshed and any training that was over-due. However, records we saw showed that the registered manager had not always taken action on the outcome of audits in a timely way before staff training became over-due.

There were additional checks to ensure staff had delivered care to people as planned. Periodic unannounced spot checks were carried out by managers and clinical staff where they observed staff working practices in people's homes. Spot checks were used to check if staff were providing care in accordance with people's care plans, followed the provider's procedures and to identify any training needs. We saw evidence that, where spot checks had taken place, appropriate follow up action was taken through staff supervision and training if any improvement was identified as being required. However one member of staff told us, "I haven't had a spot check on my working practices for months." Another member of staff told us they had yet to receive a spot check on their working practices. This meant that audits and observations of working practices were not consistently carried out to ensure staff were providing quality care.

Registered providers such as Interserve Healthcare Leicester are required by law to notify us about significant events and incidents that occur within the service. A review of our records confirmed that appropriate notifications were sent to us in a timely manner. This meant that the provider responded to concerns and involved other agencies, where appropriate, to ensure people were safe.

The registered manager kept informed about relevant local and national developments in health and social care through guidance and information supplied by the provider, through local provider forums and through sharing information with registered managers of other services within the provider's organisation.