Guild Care

Guild Care Domiciliary Care

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

The inspection took place on 12 February 2016 and was announced.

Guild Care Domiciliary Care provides support and personal care to people in their own homes. It covers the geographical area along the West Sussex coast from Littlehampton up to Southwick. People receiving home care support have a range of needs: physical and/or mental health issues, medical conditions, older people and people living with dementia. At the time of our inspection approximately 183 people received some form of support from the service.

At our last inspection to the service in June 2015, we made two compliance actions. We found the service did not have a robust system in place to assess people's risks safely, issues relating to obtaining people's consent and staff understanding of the Mental Capacity Act 2005. We asked the provider to take action and they submitted their action plan outlining what steps would be taken to meet the breach of regulations previously identified. At this inspection, we found sufficient action had been taken and the provider was now meeting the requirements of those regulations.

A registered manager was 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.

Overall, risks to people were managed appropriately. Risks had been identified and assessed and information provided to staff on how to mitigate the risks. The provider planned to introduce training to staff on the drawing up of risks assessments to ensure that risks to people were managed safely and information was relevant and up to date. We have made a recommendation to the provider relating to the review of all risk assessments within people's care records to ensure these accurately reflected people's risks. People and their relatives felt they received a safe service. Staff understood what action to take if they suspected people were at risk of abuse and had received training on safeguarding adults.

There were sufficient staff available and overall people felt that staff spent sufficient time with them, although some people stated staff arrived late occasionally. Safe recruitment practices were in place and checks were undertaken on new staff before they commenced employment to ensure they were safe to care for people.

People's medicines were managed safely and people were assessed in their ability to take their own medicines. There was no audit of medicines in place at the time of our inspection. We were told that an audit was being planned, although there was no evidence available to corroborate this development. People were supported by care staff to have sufficient to eat and drink and had access to a range of healthcare professionals and services. They were supported to express their views and to be involved in the planning of their care. People felt they were treated with dignity and respect by kind and caring staff and

that they were encouraged to be as independent as possible. People received personalised care and care plans provided comprehensive information to staff, including people's personal histories, likes and dislikes. Complaints were managed in line with the provider's policy and to the satisfaction of the complainants. However, some people felt that they could not always make contact with the office staff.

Staff had received training on the Mental Capacity Act 2005 and understood its requirements relating to gaining people's consent and making decisions. New staff undertook a comprehensive induction programme, including the standards of the Care Certificate, a universally recognised qualification. Other staff completed training in a range of areas and records confirmed this was up to date in all essential topic areas. Staff received regular supervisions and annual appraisals. They attended team meetings every quarter.

People and their relatives were asked for their views about the service and the provider had completed a survey in December 2015, together with an analysis of the results. Staff were kept up to date on what was happening through a newsletter. There was a range of audits in place to measure the quality of the service and improvements had been made since the last inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

Some aspects of the service were not safe.

Two areas were identified as areas for improvement. We recommended that the provider reviewed all risk assessments for people to ensure they were accurate and contained up to date information that reflected people's support needs. There was no audit in place to ensure that medicines were managed safely.

People felt safe using the service and staff had been trained to recognise potential signs of abuse, including what action to take. There were sufficient staff to meet people's needs. New staff were vetted before they commenced employment.

Is the service effective?

Good

The service was effective.

People were supported by staff to have sufficient to eat and drink and had access to a range of healthcare services and professionals.

Staff had received training in all essential areas and understood the requirements of the Mental Capacity Act 2005, which they put into practice. New staff followed an induction programme.

Staff had regular supervision meetings and annual appraisals; they attended quarterly team meetings.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff and their independence was promoted. They were involved in all aspects of their care and felt they were treated with dignity and respect

Is the service responsive?

Good

The service was responsive.

Care plans provided comprehensive, detailed information and

guidance to staff on how to support people in line with their assessed needs.

People knew how to make a complaint. Complaints that had been received by the provider were managed in line with the complaints policy and to the satisfaction of the complainant.

Is the service well-led?

Good

The service was well led.

People and their relatives were asked for their views about the service they received and improvements were put in place as a result.

Staff felt supported by management.

There was a range of audit systems to measure the quality of the service.

Guild Care Domiciliary Care

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.

The inspection took place on 12 February 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 someone would be in. The inspection was undertaken by three inspectors.

This inspection was carried out to see whether breaches of legal requirements formerly identified had been met.

Before the inspection, we examined the previous inspection report and notifications we had received. This included statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send to us by law. The provider also completed a Provider Information Return (PIR) which is a form that asks the provider to give some key information about the service, what the service does well and any improvements they plan to make. We checked the information that we held about the service and the service provider. We also examined the action plan that the provider had returned after the last inspection. We used all this information to decide which areas to focus on during our inspection.

Before the inspection, the Commission sent out questionnaires to obtain feedback from 50 people who used the service, their relatives and friends, 39 staff and 12 community professionals. We received 15 responses from people who used the service, three from relatives and friends and four from staff.

We observed care and spoke with people and staff. We spent time looking at records including 20 care plans and daily records, four staff files, medication administration record (MAR) sheets, staff rotas, the staff training plan, complaints and other records relating to the management of the service.

On the day of our inspection, we met with two people who were receiving care at home. We spoke with the

operations director, registered manager, head of operations and three care staff. After the inspection, we telephoned 19 people who used the service and their relatives to obtain their feedback about the service they received. We also spoke with one member of care staff by telephone following the inspection.

Requires Improvement

Is the service safe?

Our findings

At our last inspection in June 2015 we made a compliance action regarding a breach of Regulation related to the assessment of risks of people who used the service. At this inspection, we found that improvements had been made and the provider was complying with the requirements. However we have identified further improvements that could be made in this area.

Review of 20 care records showed that overall risks to people were managed so they were protected from harm and their freedom was supported and respected. People's risks were identified, assessed and documented in their care plans. For example, a risk assessment dated September 2015, updated in February 2016, had identified a trip hazard for one person. The assessment stated, 'Carers to ensure [named person] has her stick with her at all times. Encourage to remove rug in the lounge'. The person had been made aware of the potential trip hazard but had chosen to keep the rug in place next to the hearth in their sitting room. Risk assessments were in place covering a range of areas such as social, mental health, neglect, sensory and finance. In each case, the risk had been assessed appropriately and guidance/information provided to staff on how to mitigate the risk.

During one of the home visits, we observed the person had a walking frame placed at the bottom of the stairs and another walking frame at the top. This assisted them to mobilise when they reached the top or bottom of the stairs. However, the risk assessment in the care plan stated, 'Uses one stick to mobilise. Walks with stick at all times'. Clearly this was not the case as the person also used the walking frame and therefore the risk assessment did not reflect the person's current needs.

At another home visit, the person had been assessed as at high risk of falls and we observed the member of staff supported this person appropriately and brought their walking frame over when the person wanted to get up from their chair. Whilst the risk assessment had identified the person as being at high risk and contained guidance for staff, the overall risk assessment concluded they were at low risk of falls, which was conflicting advice. The registered manager concurred with our findings and stated that they planned to introduce training for staff in the drawing up of risk assessments. Some progress had been made since our last inspection and the documentation of people's risks had improved, but further improvement was necessary to ensure assessments contained all necessary information and that this was relevant and up to date.

One person had been diagnosed with Alzheimer's disease and consequently suffered from short term memory loss. Their medicines risk assessment showed that they required assistance to take their medicines and could access their medicines independently. The risk assessment form asked the question whether it was safe to allow the person to access their medicines and if there was a possibility they could tamper with their medicines. These two questions were unanswered. Consequently, it was not possible to ascertain the level of risk that access to medicines posed to the person.

We recommend that the provider review all risk assessments within people's care records to ensure that information, advice and guidance are up-to-date and accurately reflect people's risks. In addition, that

relevant staff are trained in assessing risks and are competent in drawing up risk assessments that are fit for purpose.

A member of staff talked knowledgeably about risk assessments and the various uses of these relating to mobility, skin integrity and nutrition, as examples. They told us, "If there was anything major or a change [in risk] I would let the office know by text or speak to them direct". This ensured that people's needs were monitored regularly by visiting care staff and any changes to risk assessments were made.

Responses from the Commission's questionnaire showed that 100% of people and their relatives felt safe using the service. Comments received following telephone interviews with people were, "Oh yes, we feel safe when they [staff] are here", "Yes, they ask me if I am all right and make sure the door is closed when they go" and "Yes, I do feel safe. They let themselves in, I have a key safe". Staff we spoke with had undertaken training in adult safeguarding within the last year. One staff member explained what action they would take if they suspected abuse was taking place and said, "I would let my manager know if I saw something going on". Another member of staff told us about the different types of abuse such as financial, sexual or physical and said, "I would report it immediately to the office. Hopefully they would contact Social Services or the police depending on the severity of abuse". Staff felt that the responsibility for reporting any safeguarding concerns lay with the office staff and that any appropriate action would then be taken by the local authority.

We asked people whether there were sufficient staff available to ensure that home visits were undertaken punctually and in line with people's preferences. Results from our questionnaire confirmed that staff attended the home visit for the allotted time and completed all tasks satisfactorily. People who responded to our questionnaire had mixed views about the consistency of care they received. One person said, 'I wish the office would stop taking my regular carers away. They do not ring when there is a change' and another person had a similar view stating, 'Don't agree to my care workers being changed at the last moment and not being notified of it'. However, a third person said, 'Guild Care is a friendly, caring service. Timing of visits can be unreliable, but this is sometimes understandable'. A member of staff who provided feedback told us, 'The allocated time that some service users have doesn't always meet their particular care needs. For example, I have been at some clients for longer than their time allows because I haven't wanted to rush them. I haven't claimed extra time due to the paperwork involved. I don't like to hurry people … it can leave me late for the next person'. Visiting schedules showed that people usually received care from the same members of care staff and that changes to staff did not occur regularly. Wherever possible, people were allocated the same members of staff consistently.

We asked one person we met whether staff would let them know if they were going to be late. They told us, "I'm sure they would, but it doesn't bother me if they're late". Other comments from people included, "I don't mind if they are late, it's usually only 10 minutes", "They are often not on time, but that's because of the traffic" and "It's up and down, but they are getting better lately I must admit". A member of staff said that travelling time between calls could sometimes make them late, especially at certain times of day when traffic was busy. We asked staff about the amount of time they had to spend with people at each visit. One staff member said, "I think that's improved quite a lot lately. There is enough time now most of the time. I did visit someone who I thought needed more time. I spoke with the manager and the time given was increased".

Visiting schedules for the previous two weeks showed there was a small number of visits of 15 minutes' duration. We asked the registered manager about these and they told us these appointments were only used either for people who required minimum input such as medicines prompts or had requested this amount of time themselves. Documentation confirmed this with most time slots of between 30 – 60

minutes, with the longest visit of two hours' duration.

The service followed safe recruitment practices. Appropriate checks were undertaken before staff commenced employment. Staff files contained recruitment information that included criminal records checks with the Disclosure and Barring Service. This meant the provider had undertaken appropriate recruitment checks to ensure staff were of suitable character to work with vulnerable people. There were also copies of other relevant documentation including character references, Home Office Right to Work checklists and interview notes. In addition, there was documentation related to care staff who used their own cars to visit people at home, which included copies of driving licences, up to date car insurance and MOT certificates.

People's medicines were managed so that they received them safely. People had risk assessments drawn up relating to the administration of their medicines and these had been completed appropriately and were contained in the care records. Some people took their medicines independently, some needed reminders or prompts from care staff to take their medicines, whilst others relied on care staff to administer their medicines. We observed a member of care staff handing a person their medicines on a home visit. The member of staff explained to the person what each medicine was for and checked to see that all medicines had been taken as prescribed. We asked the person about the management of their medicines by staff and they replied, "I just take what I'm given!" Staff confirmed that they received training in the administration of medicines and this was refreshed annually. One member of staff explained, "I've just booked in for my next update. I prompt or administer people's medicines and I check the blister pack to make sure relevant days have been taken".

We spoke with the registered manager and the head of operations about audits of medicines as there had been 25 medicines errors recorded in the previous 12 months. These errors related to gaps on the Medication Administration Records (MAR), where medicines had been administered, but staff had omitted to complete the MAR to this effect. There was no medicines management audit system in place at the time of our inspection. We were told this was currently being worked on and would be ready for use within the next few weeks. However, although the provider was able to describe the methods to be used, they were unable to produce evidence of its development. In the Provider Information Return (PIR), the registered manager stated that they intended to identify a member of staff who would take the lead in medicines management and provide additional support to staff in this area.

Good

Is the service effective?

Our findings

At our last inspection in June 2015 we made a compliance action regarding a breach of Regulation related to consent and staff understanding of the Mental Capacity Act 2005. At this inspection, we found that improvements had been made and the provider was now complying with requirements.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and staff understanding of the requirements of the MCA. Staff received training on the MCA and one member of staff told us the training consisted of a two hour session, delivered on line. They explained their understanding of the MCA and told us, "Basically assume, irrespective of what the person looks like, that they have got capacity to make their decisions. In terms of assessment, we rarely meet with friends and family. I try and give people as much as they need, check their understanding and consequences of making a particular decision". They provided an example of one person who had refused to take their medicines because they felt they, "did not agree with her". As a result, the GP was consulted resulting in a change of medicine. Another staff member told us they had undertaken recent training in this area and had a good understanding of the implications of the MCA, including the nature and types of consent, people's right to take risks and the necessity to act in people's best interests when required. They told us, "People should be allowed to take risks, especially in their own home". Care plans contained mental capacity assessments, where appropriate, for example, where relatives had expressed concerns about a person's ability to make decisions for themselves.

Responses to our questionnaire showed that 93% of people felt that care staff had the skills and knowledge they needed in order to carry out their roles effectively. The same number of people felt that care staff supported them to be as independent as possible. Relatives all felt that care staff were appropriately trained and staff too felt they had received all necessary training. In our telephone interviews, one person told us, "I think they all have training and the right skills. They often go off on training days, I know that". Another person said, "I think my regular ones have had the right training. I have a catheter and they know exactly how to look after it to stop infection getting in". A third person, when asked whether they felt staff had sufficient skills and training, said, "Well I should jolly well hope so!"

New staff undertook a full induction programme and shadow experienced staff before undertaking home visits independently. All new staff completed training in a wide range of areas and were given the different standards of the Care Certificate, covering health and social care topics, which the provider had introduced. These courses are work based awards that are achieved through assessment and training. To achieve these awards candidates must prove that they have the ability to carry out their job to the required standard. After successful completion of their probation, staff were offered several short courses through the Qualifications and Credit Framework at level 2 and 3 in a variety of topics such as Certificate in Common Health Conditions, Handling of Medicines and Understanding the Care and Management of Diabetes.

Staff told us about the training they had received in a range of areas such as infection control, health and safety, moving and handling, fire awareness, safeguarding vulnerable adults, first aid and food hygiene. The 2015 training plan also showed that other topics included equality and diversity, the Mental Capacity Act 2005, medication management and working at height.

We noted only 11 care staff out of 65 had completed dementia care training within the past 12 months, despite the fact that approximately 70 out of 183 people using the service had some form of dementia. One staff member told us they had not received any dementia care training in the 14 months since joining the provider. We raised this issue with the registered manager who stated they would organise dementia awareness training for all staff and link this to training on mental capacity.

Supervision sessions and yearly staff appraisals for all staff had been undertaken or was planned, in line with the provider's policy. One member of staff when asked if they received supervisions said, "We had a change of manager and it did go down a bit. Now we have them every three months". They told us that they would discuss any general issues at supervision and these were usually related to the people they looked after. The same member of staff said that a senior member of staff also undertook spot checks and observed them delivering care at home visits. They described what happened at their observation last August and said, "Staff looked at my uniform and at infection control, that I read the care plan and communicated well with the client".

Staff also confirmed that team meetings were usually held every two or three months and that a list of team meetings planned for 2015 was made available to them. The registered manager explained that team meetings were held at three different times on the same day, thus providing opportunity for all staff to attend. In the Provider Information Return (PIR), the registered manager stated, 'All team meetings to include at least one policy to discuss. All team meetings to include 'bite sized' training on care practice. 'Read and sign' file to be introduced to ensure staff have read policies and procedure'. Minutes were recorded and records showed team meetings were held every three months. Meetings were well attended and staff were able to discuss matters of importance to them and the people they were looking after. The minutes did not contain a review of the minutes of the previous meeting or an action plan for the current one. This meant it was not possible to ascertain whether issues raised previously had been resolved. We brought this to the attention of the registered manager, who agreed that actions arising should be recorded and agreed to implement this at future team meetings.

During the home visits, we observed that care staff ensured people had sufficient to drink throughout the day, replenishing or replacing cold drinks or making people hot drinks. Some staff helped people by heating up meals for them in the microwave. Daily records showed that care staff documented how much people had eaten or drank throughout the day. One member of staff explained how they would encourage people who were at risk of malnourishment. They told us, "A few people are on supplementary drinks. I prompt them to take them".

People had access to healthcare services and professionals. Care staff told us they would contact the emergency services if necessary and care plans provided advice and guidance to staff. For example, one care plan stated, 'Carers must contact emergency services if [named person] becomes unwell'. Care plans showed that the provider involved a wide range of external health and social care professionals in the care of people. These included occupational therapists, telecare providers and GPs. Advice and guidance given by these professionals was followed and documented in the care plans.

Good

Is the service caring?

Our findings

Positive, caring relationships had been developed between people and staff. In our questionnaire, responses to the question, 'My care and support workers are caring and kind' were 100% positive. We asked people whether they were treated with respect and comments referring to staff included, "They are all lovely, really lovely", "They are all very nice indeed; they do a good job" and "They always ask which perfume I would like on each day". One person confirmed that staff were kind and caring and told us, "Yes, they moved the daffodils from my balcony closer, so I could water them". The majority of care plans we looked at contained both life histories and social assessments for people. They had been compiled in conjunction with people and their families where possible and contained information staff could use to help build relationships, for example, people's previous occupations and hobbies. At a home visit, one person became quite distressed over a particular issue and care staff responded reassuringly to the person and said, "[Named person] darling, don't worry about that, we see lots and lots of people every day". Another member of staff told us, "I just enjoy helping people. A lot of them are isolated and it's nice to be there for them".

People were supported to express their views and were actively involved in making decisions about their care, treatment and support. A relative explained, "She knows them all and they know her very well. I've heard them asking her about things". Another person said, "Yes they do. If I ask them to change something or do something different, they just do it, it's no problem". A third person said, "Yes, someone from the office comes and we discuss my needs". We looked at care plans and daily records. All care plans and risk assessments were reviewed six monthly and signed by staff. There was evidence that people and their representatives had regular and formal involvement in care planning and risk assessment and their views were sought and taken account of. A member of staff explained how they would obtain people's consent and said, "I just ask them and check they agree. I always ask them, I don't tell them and I offer choices. I try and encourage people and negotiate with them".

People were encouraged to retain as much independence as possible. For example, one person's care plan stated staff should, 'Allow [named person] to take the lead' with domestic chores as part of their re-enablement. One person felt their independence was promoted and told us, "I'm 94 and they help me with my housework". Another person said, "They do my housework, wash me, do my feet and go shopping for me. I help them where I can, we do it together". A third person told us, "They help me shower every morning. They come three times daily to help me. I couldn't stay at home if it wasn't for them".

In our questionnaire, we asked people whether they felt staff treated them with dignity and respect and 100% of people agreed that they were treated well by staff. During telephone interviews, people were positive about staff and comments included, "Yes, they speak to me nicely" and another person stated, "Always polite and caring. I really look forward to them coming". People told us that staff knew them well, how they liked to be cared for and their preferences. One person said, "They know what I like, they've been coming to me for a long time". Another person said, "Oh yes, they know that, they ask how I like my eggs cooked". A third person told us, "Yes, they know what I do and do not like. For example, I don't like my face washed with a wet flannel, so they use wipes". People also said that they had a choice of whether they

wished to be cared for by male or female care staff. One person said, "I do have one man come sometimes. He makes my sandwiches. I don't mind that one bit". Another person said, "I don't have male carers. It wasn't a problem". We asked another person if staff had time to chat with them and they said, "Yes, if I want them to, but they're busy people".

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. One relative explained, "My wife's just broken her hip and they often ask me how best to do things". People confirmed they were involved in the planning of their care and one person said, "Yes, we have been involved" and that, "Someone comes from the office from time to time to make any changes if we have needed them". Another person said, "No, they just do it all for me, I've got no complaints". Some people were aware of the care plans in their homes, with one person stating, "Yes, I have one, all my information is in it. They [referring to staff] look at it when they come". Another person thought they had a care plan and said, "Yes, I think so. If something needs changing, we write it in the book". In our questionnaire, we asked people whether they were involved in decision making about their care and support needs and 87% of people confirmed they were.

People's care plans and daily records were legible, relevant and up to date; these included the care plans kept at the office and care plans in people's homes. They contained information about people's care needs, for example, in the management of risks. The majority of care plans contained information about people's personal histories, their likes and dislikes. People's choices and preferences were documented. The daily records showed that these were taken into account when people received care, for example, in their preference for shopping items brought to them by care staff.

People's needs were assessed appropriately and care and treatment was planned and delivered to reflect their individual care plan. Care plans contained detailed and comprehensive information for staff on how to care and support people in line with their assessed needs. For example, one person suffered from anxiety and had a history of mental illness. The person's care plan contained a mental capacity assessment and detailed information for staff about triggers for panic attacks and the strategies needed to minimise their effect. The same person preferred to sleep in a chair rather than use their bed. This represented a number of risks to the person, including the possibility of damage to their skin integrity. This had been explained to the person and measures put in place to assess and minimise the risk. However, the provider had already established the person had full mental capacity and respected their right to take risks. Care plans also recorded goals and outcomes for people that had been drawn up following consultation with them. For example, one care plan recorded, '[Named person] would like to remain safe and independent at home for as long as possible'. People were encouraged to maintain interest in their hobbies and leisure pursuits. During a home visit, one person enjoyed playing the piano and asked us if we could identify the particular songs (Smoke gets in your eyes and Charmaine). The registered manager told us that they hoped to undertake some home visits in the future so they could meet with people and improve their understanding of the service delivered.

We asked people how they would make a complaint if they had any issues or concerns. People knew who to contact and felt comfortable to do so if they needed to. One person said, "Yes, we phone the office. We have done in the past and it just gets sorted". Another person told us, "There's a form somewhere isn't there?" There was a feedback form within people's home care files which they could use if they wished to raise any issues or feedback of the service. A third person said, "Yes I do know what to do thank you. I tell my son and he sorts it". During a home visit one person told us, "I've got no complaints at all. I've got good

souls coming in". Responses to our questionnaire were not so positive however. One person stated, 'On many occasions the telephone is not answered or there are recorded messages'. Another person said, 'I have no problem with the carers who come three times a day. However, the office staff are difficult and never have time to listen to my queries. On one occasion they even put the phone down on me'. A third person said, 'I recently needed to contact the senior member of staff and they did contact me. Anyone lower down the scale just ignored any phone calls'.

We looked at the provider's complaints policy and procedures which were displayed in the reception area of the provider's head office. We also looked at the complaints log. The complaints policy included clear guidelines on how and by when issues should be resolved. It also contained the contact details of relevant external agencies, such as the Care Quality Commission, if people felt their complaints had not been dealt with satisfactorily.

Eleven formal complaints had been made in the past year. We looked at the documentation relating to five of these. The complaints had been resolved in a timely and satisfactory manner. The registered manager had written to the relevant parties with an action plan, where necessary, to prevent reoccurrence of the issues.

Good

Is the service well-led?

Our findings

In our questionnaire we asked people whether Guild Care Domiciliary Care had asked them for their feedback about the service they received. Just over half responded that their views had been sought and 13% said they did not know. A third of relatives said they had been asked for their feedback. The majority of people we spoke with over the telephone seemed unsure about whether they had received a questionnaire or survey from the provider about the quality of the service. One person said, "Yes, from CQC, but not from Guild Care". Another person said they did receive questionnaires, "Occasionally, but we don't fill them in". The provider gave us a copy of their home care survey completed by 75 people in 2015. The majority of people felt that care staff were kind and caring and that they were treated with respect. Fifteen people stated that the office did not let them know about changes to their call times and everyone was offered the opportunity to have a meeting to discuss their review of the service. Comments overall were positive such as, 'The care is for my mother who wasn't keen, but has now changed her mind and looks forward to the visits', 'I have received wonderful care and attention' and 'They make a good cup of tea!'

A newsletter had been produced by the management team and had been sent to all staff at the end of 2015. The newsletter featured dates of team meetings, the Mental Capacity Act 2005, risk assessments and the importance of professional boundaries. The registered manager stated, 'May I stress that my door is always open to all of you and you can contact me by phone, email or in person. I will always listen to you in confidence and, where there are genuine issues, I will ensure that you are protected under the whistleblowing policy'. We asked a staff member if they thought the service was well led and were told, "Yes, definitely. I can always go to the manager if I have a problem". Another member of staff felt the service was well managed and they felt supported. They talked about the culture of the service and told us, "I think we generally give a good dependable level of care with carers they can trust".

The service undertook a range of audits to measure the quality of the service. Since our last inspection, the provider had reviewed the way people's risks were assessed, including medication risk assessments, and had introduced a new format which had led to an improved method of risk assessment. Where bed rails had been fitted, a bedrail assessment was put in place. Mental capacity assessments, where required, were in place. A pressure mattress monitoring system had been introduced to ensure mattresses were at the correct pressure setting and care plans had been updated relating to pressure care treatment and skin integrity. A checklist was in place for reviewing care plans to ensure they were up to date and contained all relevant information about people. Guidance was in place for staff concerning the completion of fluid and nutrition charts for people. The provider had introduced additional training on mental capacity and updated safeguarding training. A system was in place to ensure that people were notified when alterations had to be made to their allocated staff or times of care calls. Staff had supervision meetings at least quarterly and a survey to ask staff for their feedback about the service was planned for March 2016.

The service had recently created a new post, Head of Operations, to increase management support and there were plans to provide an additional resource to improve assessments for people. The registered manager felt that improvements had been made to improve the quality of care delivered and said, "I feel quite positive about the way the service is going".