Caretakers (SW) Limited

Caretakers SW Limited

Inspection report

Suites 1-3
62 Hyde Road
Paignton
Devon
TQ4 5BY

Tel: 01803668521

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09 May 2018
10 May 2018
22 May 2018
11 June 2018

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Caretakers (SW) Limited is domiciliary (home care) service. Personal care was provided to 87 people at the time of the inspection. Due to two location changes the service had not been inspected since November 2013. This was therefore the service's first inspection under the new methodology.

Domiciliary care services provide personal care to people living in their own houses and flats in the community. People's care and housing are provided under separate contractual agreements. CQC does not regulate premises used for supported living; this inspection looked at people's personal care. Caretakers (SW) Limited is registered to provide personal care to older and younger people and people who have learning disabilities. Some people had additional services offered by the provider including domestic, recreational and companionship help.

This inspection took place on the 9, 10, 22 May 2018 and 11 June 2018. 72 hours' notice was given as we needed to be sure the registered manager would be available when we visited the agency offices. This was the first inspection of the service since it had moved location.

The service 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 support plans required developing to be more individualised and describe how they liked their needs met and their individual routines. Care plans needed to be more comprehensive to include the role of staff in medicine administration and where health needs such as diabetes had been identified. End of life care plans and people's end of life wishes needed to be incorporated into care records. Risk assessments required more detail to reflect staffs role in mitigating risks in relation to skin care. The provider's governance and quality assurance systems needed improvement to ensure issues such as this could be identified and action could be taken to improve.

People and relatives told us they were well cared for by staff. People had regular reviews to ensure the service provided to them changed as they did. No one had any complaints about their care. Feedback from all people and relatives was very positive. The management team were open and approachable. The provider and registered manager listened to feedback and reflected on how the service could be further improved. Some people and staff told us communication could be improved for example when there were changes to rota's and timings of visits. Staff told us the lack of travel time between visits was an area for improvement.

People were protected from harm and discrimination. People's human rights were protected because the code of practice in relation to the Mental Capacity Act 2005 (MCA) was followed. Staff told us they always asked people for consent and explained what they were doing. However, people's and ability to consent was

not incorporated in to their care plans. People's nutritional needs were met because staff followed people's support plans to make sure people were eating and drinking enough and potential risks were known.

People were treated equally and fairly. Staff adapted their communication methods dependent upon people's needs, for example simple questions where people had cognitive needs and loud clear speech if people had hearing impairment. Verbal information and explanations about care were given to people with cognitive difficulties and was available in a different format if people required information.

People were supported by staff who were compassionate, kind and caring. All staff demonstrated kindness for people through their conversations and interactions. People were supported by a consistent staff group who knew them well. People's privacy and dignity was promoted. As far as possible, people were actively involved in making choices and decisions about how they wanted to live their lives. People were protected from abuse because staff understood what action to take if they were concerned someone was being abused or mistreated.

Risks associated with people's care and living environment were effectively managed by staff to ensure their freedom was promoted. This was because staff knew people well. People's independence was encouraged and staff helped people feel valued by engaging in everyday tasks where they were able to.
The provider and management team wanted to ensure the right staff were employed, so recruitment practices were safe and ensured that checks had been undertaken. Staff underwent a thorough induction and ongoing training to meet people's needs effectively. People's medicines were administered safely but the care plans relating to medicine administration and the role of staff in prompting or supporting a person required development.

People received care from staff who had undertaken training to be able to meet their unique needs. Some staff were "champions" in specific areas and staff we spoke with told us the training was good and they felt skilled and confident. People were supported to access health care professionals to maintain their health and wellbeing.
People were protected from infection by staff that were trained in this area and used gloves and aprons where required. People told us their homes were left tidy and clean.

People we spoke with did not have any complaints and were confident raising minor concerns with the office staff.

We found one breach of our regulations in relation to care plans and people's records.

You can see what action we told the provider to take at the back of the full version of the report.

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

There were sufficient staff employed to meet people's needs safely.

Staff were recruited safely.

People were protected by staff who could identify abuse and who would act to protect people.

People were supported by staff who knew there risks well and acted to protect people. Although risk assessments were in place to mitigate risks associated with people's care, these required greater information to guide staff on what action to take.

Staff followed safe infection control procedures.

People were supported to receive their medicines in a safe way but care plans related to medicine management required development.

The lack of sufficient travel time affected the timeliness of visits. People told us they knew to expect staff 30 minutes either side of an appointment and were contacted when staff were running late.

Is the service effective?

Good

The service was effective.

People received support from staff that knew them well and had the knowledge and skills to meet their needs.

Staff were well supported and felt confident contacting the management team to ask advice.

Staff had a good understanding of consent and the Mental Capacity Act. Choice and independence was promoted whenever possible.

Is the service caring?

Good

The service was caring.

People were looked after by staff that treated them with kindness and respect.

People and family spoke highly of staff. Staff spoke about the people they were looking after with fondness.

People had as much control as possible of their care and staff listened to them.

People said staff protected their dignity.

People were supported in their decisions and given information and explanations in an accessible format if required.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Care records required development to reflect people's individual needs and end of life wishes.

People received personalised care and support, which was responsive to their changing needs.

People were involved in the planning of their care and their views and wishes were listened to and acted on.

People and those who mattered to them had information about how to make a complaint and raise any concerns.

Is the service well-led?

Requires Improvement

The service had a supportive management structure in place.

There was a positive culture in the service. The management team provided positive, supportive leadership and led by example.

Governance systems required improving to identify and act upon the issues we found at the inspection.

The provider and registered manager had clear visions and values about how they wished the service to be provided and these values were understood and shared with the staff team.

People's, family and professional feedback about the service was sought and their views were valued and acted upon.

Staff were motivated and inspired to develop and provide quality

care.

Caretakers SW Limited

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 May 9, 10 and 22 2018, was announced and undertaken by one inspector. Responses to 50 questionnaires we sent out were reviewed on 11 June 2018.

Before our inspection we reviewed the information we held about the service. We reviewed notifications of incidents that the provider had sent us since their registration. A notification is information about important events, which the service is required to send us by law.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well, and improvements they plan to make. Due to technical problems we were unable to review the full contents of the PIR until 11 June 2018.

During the inspection we spoke with the nominated individual, the registered manager, the office manager who was in charge on a day to day basis, and two senior staff members. We also spoke to an external trainer who provided a training service to the provider two days a week.

During our inspection we met with one person receiving a service, one person cancelled and one had gone out when we visited. We spoke with one relative.
We looked at five records which related to people's individual care needs. We viewed four staff recruitment files, training evidence and records associated with the management of the service including compliments received. We reviewed policies and procedures, incidents which had occurred, people and staff feedback, and the complaints process.

Following the office inspection we telephoned four staff, one relative and spoke to another person receiving care on the telephone. We also received 7 comment cards from people receiving a service. The Commission

sent out 50 questionnaires to people for their views on the service. 22 questionnaires were returned.

Requires Improvement

Is the service safe?

Our findings

People, relatives and professionals said the service was safe but we found there were some areas which required improving. These included travel time, more comprehensive risk assessments and prompt alerting to the local authority in the event of a safeguarding concern. Care plans in relation to diabetes required developing.

People were supported by staff who managed risk effectively. We found there were environmental risk assessments in place which considered hazards within people's home and external risks assessments in place. Where people had risks in relation to their skin or health needs staff were aware and managed these risks but we found care plans required further information and detail to guide staff. For example one person we reviewed had diabetes and fluctuating blood sugar levels. Staff were recording their blood sugar and supporting administering their insulin under the direction of the district nurse but there was no guidance on how to respond if the person had high or low blood sugar. This may mean staff did not respond consistently. The provider advised staff were trained in diabetes and would know what to do in the event the person was unwell due to their diabetes.

Other people were vulnerable to skin damage and risk assessments failed to identify this or guide staff how to mitigate risk for example through pressure relieving equipment, repositioning and skin creams. Therefore, there was no written information to ensure staff were consistently knowledgeable about how to mitigate identified risks.

However, staff confidently told us how they cared for people's skin, checked for pressure areas, applied creams and ensured people had the equipment they required. Staff explained how one person they worked with now needed more time to walk as they had become more frail and prone to falls; they were patient and encouraged the use of walking frames and ensured their emergency call bell was on before they left the person's home.

Following the inspection the provider was looking to improve the risk assessments and care plans to reflect the care given. They sent an example of the new paperwork to the Commission.

People and relatives confirmed home visits were never missed and they were notified if staff were running behind schedule, "I am happy with the service and timekeeping". However, most staff told us that the lack of travel time was an issue which affected their schedule. We spoke with the office staff about this area. They explained if people lived in the same area there was no travel time. They would never leave someone early if they required help for their full time but the lack of allocated and sufficient travel time caused visits to be late. Staff explained travel time did not always allow for the summer season when traffic was heavier or there were planned road works on a route. One relative shared, "Some carers fly in and fly out even though you have paid for the allocated time. "We spoke to the manager following the inspection who told us they would address this area. One person also mentioned care staff arriving when the appointment had been cancelled for example, if someone was admitted to hospital. The manager explained that the office is not always informed of someone going in to hospital which can cause this problem.

People had information about the staff who would be visiting them in their homes so they knew which staff to expect on particular days. One person told us they had some problems with their rota arriving in the post and we asked the office to follow this up. They also told us some of their regular care staff were changed sometimes with no notice or explanation. Another relative also commented on this, "My father, at present, only has a service for half an hour once a week to provide personal care.
Staff are always kind and caring. My only small issue would be the lack of continuity of the carers. We tend to have lots of different carers." We fed back these areas to the manager. However, in a questionnaire we sent out which had a 44% response rate, over 80% of people were happy with the length of time staff spent with them and with the continuity of care staff they had. For people with visual impairment, rotas were available in large print if required. Contingency plans were in place for bad weather for example a larger vehicle had been used in the snow last winter and staff had walked on foot to ensure people received care. A thank you card we read shared, "Thank you to all the way you continued to look after my mother, [X] during the two recent heavy snowfalls."

People were kept safe by staff who understood how to identify the signs of abuse and what action they would need to take if they witnessed or suspected that someone was being mistreated. This included an understanding of which external agencies they would need to alert. Staff were aware of and prevented people being discriminated against and monitored people's behaviour for any signs which might indicate they were unhappy. For example, staff told us because they knew people well they would know when there was a problem. Others told us, "I monitor people's mood, body language, look for marks and bruises; whether they are quiet or withdrawn. I'd document my concerns and report anything to the office." Records and the management team confirmed that they had undergone training in this area, knew how to safeguard people and care for their property and belongings. Staff all confirmed they would not hesitate to raise concerns. The office staff informed us they always updated the local care trust telling us, "Safety is paramount." We discussed ensuring the service also informed the local safeguarding team as routine when staff concerns constituted possible harm to people. This would ensure safeguarding incidents were reported to the local authority and investigated if required.

People were safely supported with their medicines if they required. Staff who were responsible for administering medicines received training and their competency was checked to ensure they were safe and followed the provider's medicine policy. Records were in place in relation to specific medications, for example body maps were used for skin creams. Staff told us they felt confident administering medicines and most came in blister packs to make administration easier. One staff gave an example of providing explanations and reassurance to one person who could become confused about the medicines they took.

People were supported by staff that were safely recruited. Records showed and staff confirmed that the necessary checks were undertaken prior to an applicant commencing their employment, to help ensure the right staff were employed to keep vulnerable people safe.

People were kept safe by sufficient numbers of staff which meant there was adequate cover for sickness and unforeseen events. There was a flexible, stable staff team; this helped to provide continuity for people and meant if people had appointments there was flexibility with the times of visits. As far as possible, staff told us they worked as a team to meet people's needs so people were supported by staff they knew.

Staff were protected whilst lone working, for example when staff joined the organisation they were informed of what action they should take to ensure their safety. A lone working policy was in place and an out of hour's service to support staff safety and ensure people having early or late visits received them. Staff vehicle MOTs and car insurance were checked quarterly to ensure people were safe if they were travelling with staff. Staff told us they had torches, an alarm, parked in well-lit places and kept their mobile phones charged. One

staff member told us that the staff on call did not know the clients in one area which was not helpful when they needed advice. We fed this back to the manager who told us, "We have a senior carer for each area on-call, they are in touch with each other at all times, if ever a query arises that on-call senior is unsure off they always contact the other senior for feedback and this is then relayed back to the staff member concerned. All seniors on-call and staff members working out of hours are given all up to date information on clients (as we have it) prior to commencement of duties. Unfortunately we are not always informed of hospital admission/discharge and deaths etc by either family or other professionals. As soon as we are made aware, we act accordingly."

Staff understood the importance of a person's choice, regardless of disability, to take everyday risks and to keep people safe but not be intrusive when they monitored them in their home. Staff balanced actively supporting people's decisions so they had as much control and independence as possible with ensuring their safety at all times. Staff gave examples of how they supported people to manage their own mobility as far as possible but being mindful of potential risks and ready to step in and support as required. Other staff told us how they encouraged people to wash areas they could reach to support their independence.

People were protected from the risk of infection. People told us staff took the necessary precautions when undertaking personal care for example wearing protective clothing such as gloves and aprons. A relative told us, "I always feel safe with the carers when I leave them with [X- their relative]." Hand hygiene audits had recently been introduced and the office had an ultra violet lamp which checked staff hand cleanliness to remind them of the importance of good hand washing to reduce the risk of infection and cross contamination. People confirmed their homes were kept clean and tidy and staff supporting them with meals, prepared and served food safely. Staff told us they would always clean up spillages if they saw them to support people to maintain a clean environment.

People were kept safe by staff who understood what action to take in the event of an incident and followed internal procedures for reporting and documenting these. One staff member explained the action they had taken on arriving at one person's home and finding them on the floor. Staff had received fire training and were aware of the exits in people's homes and emergency procedures to follow in the event of a fire. Incidents which occurred were recorded and analysed to improve safety. Safety hazards within people's homes were removed or family informed such a trip hazards. For example, staff shared an example of a dangerous cooker which was replaced.

Good

Is the service effective?

Our findings

The management team (Nominated Individual and Registered Manager) understood their responsibilities in relation to the legislative framework, The Mental Capacity Act 2005 (MCA). 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 people lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and the least restrictive option available.

We spoke with staff about how they helped people make decisions to ensure consent was obtained. Staff told us how they explained the care they were providing and gave explanations in a way people would understand. Where people did not have the ability to consent to care decisions, staff understood complex decisions would need to be made and recorded under the best interest process with professionals, family or advocates. Those people who did not always recall why staff were visiting were given explanations and reassurance to help remind them of the staff's role. Staff told us if they had concerns about people's ability to consent or people refusing personal care, they would seek support and advice from the office. No one we met or spoke with lacked capacity to consent to their care. Our discussions with staff evidenced they acted in people's best interests and they understood least restrictive principles, but the recording of this in people's care plans required improvement. Some staff told us the training in this area had been, "quite a lot to take in" and no staff were able to explain the principles of the Code or why it was in place. We spoke to the manager about further training in this area for staff. The management team were improving care records and intended to incorporate people's capacity into care plans.

When staff joined the organisation they received an induction and staff new to care had the opportunity to complete the care certificate. The care certificate was a recommendation from the 'Cavendish Review' to help improve the consistency of training of health care assistants and support workers in a social care setting. Staff new to care had the opportunity to shadow more experienced staff until they felt competent.

People were supported by staff that were trained to meet their needs. Staff underwent training in the subjects such as moving and handling, fire training, equality and diversity, and safeguarding. A new moving and transferring train the trainer programme was being commenced and staff trained as champions in key areas such as pressure care. Some staff had undertaken further health and social care qualifications also. All staff confirmed the training was good and the registered manager told us training was also given to staff to meet people's specific needs for example in relation to their continence or diabetes. Relatives confirmed staff who visited their homes and needed to use equipment such as hoists, had been trained and they felt confident in their abilities.

Staff were supported by ongoing informal and formal face-to-face supervision, spot checks, competency checks and an annual appraisal. Staff were invited to come into the office regularly and staff and the management team confirmed an "open door" policy. Open discussions provided staff the opportunity to highlight areas of good practice, identify where support was needed and raise ideas on how the service could improve. All staff told us they felt supported and valued.

People's nutrition and hydration needs were met. People's care plans required further details to help staff know what people's nutritional likes and dislikes were but staff familiar with people knew these details. Staff less familiar told us they would always ask people what they liked to eat anyway in case they preferred something different to what was recorded. Staff shared how in the warmer months they would encourage people to drink more to stay hydrated and maintain their well-being.

People were protected by staff who acted in their best interest to make prompt referrals to relevant healthcare services when changes to health or wellbeing had been identified. Staff knew people well and monitored people's health on a daily basis. If staff noted a change they would discuss this with the team and people's district nurse or GP. Staff also gave examples of liaising with people's pharmacist to ensure medicines were delivered.

Technology was being used to improve care. For example the service was part of an initiative to improve care for people at risk of urine infections, falls and skin damage. This joint working with NHS colleagues would support people to live healthier lives and receive ongoing healthcare support.

Good

Is the service caring?

Our findings

The service was very caring. Family told us, "More than happy; [X] gets on well with all the care staff, they go out of their way to make him happy". People told us, "I'm please, they are all brilliant, and they are part of the family." Staff told us they cared for people like they would if they were visiting their own parents or family members. 100 per cent of people in the questionnaire the Commission sent out, confirmed the care they received supported people to be as independent as possible.

The service was a well-established, small, family run business. Some people had been supported for a long time and seen as part of the family and they mattered. The values of the organisation were to support people to be part of the community and provide inclusive care.

People and relatives all told us staff were kind and caring and feedback forms also confirmed this. People and relative comments included, "The girls go above and beyond – genuinely caring; when mum was in hospital they phones and texted to see how she was off their own back"; "They hugged me to death when I came out of hospital they were so pleased to see me"; "They are a good group of girls"; "They are polite and courteous, more like mum's friends." People who responded to our comment cards shared, "The staff are very caring and treat me with dignity and respect"; "My needs are listened to"; "Very attentive"; "Caretakers have always treated me with dignity and the greatest of respect."

Staff spoke of people in a caring, thoughtful way. All staff told us how much they enjoyed their jobs and liked the people they cared for. Staff maintained people's privacy and dignity when supporting them with personal care sharing examples of closing people's curtains, covering them with towels and giving privacy when they wished for example if they wanted to use the bathroom alone. Another staff member shared that although they had the key safe entry code they knew one person liked to answer the door to them so they made sure sufficient time was given for her to get up and open the door so she could greet and welcome staff herself. All staff shared small things they did when they had time to make people feel they mattered, these included fetching milk and bread, picking up a newspaper if family were away and one staff member said they always made sure the rubbish was put out after being asked to do this once. Staff shared on example of how one person they visited worried about their weight. Staff said they always tell her how beautiful she is which she liked to hear.

Confidentiality, the Data Protection Act and personal boundaries were understood and respected by staff. Staff spoke to us about how people would be treated and cared for equally regardless of their sexual orientation, culture or religion. They gave examples of people they had previously cared for but all said they would be treated as individuals, according to their needs.

Staff ensured people were supported and cared for as they would their own family. Staff rota's were organised around people's needs and arranged so staff had time to listen to people, provide information and involve people in their care. Staff told us they used to visit and take one person out on drives but as their health had deteriorated they no longer wanted to do this. Now, staff explained they used the time to sit with them, listen to the radio and offer them some company. The values of the organisation ensured the staff

team were compassionate, respectful and empathetic and this was evidenced through our conversations with staff and people's descriptions of the care they received. People, where possible, received their care from the same staff member or group of staff members. This suited people and they told us they appreciated not having to repeat information. It supported relationships to be developed with people so they felt they mattered. Staff we spoke with also preferred visiting the same people so they got to know them and their routines.

People's background, social interests and preferences were not always recorded. We spoke with the management team about developing care records to incorporate this information to help build relationship and conversation. This information would be particularly helpful for new staff.

People confirmed they were supported to stay as independent as possible, for example staff would support them to wash areas of their body they were able to independently, but assist them with areas they could not reach. Staff worked at people's own pace to enable them to remain independent and care as much for themselves as possible.

People told us how the service had helped to improve their lives by promoting their independence and well-being. One person said; "I wouldn't be able to be here (in their own home) without them and my daughter".

People's care plans detailed family and friends who were involved in their care. This helped staff to be knowledgeable about people's family relationships and enabled them to be involved as they wished. People and their relatives confirmed they were encouraged to be involved in all aspects of care. Regular reviews with people and those that mattered to them were in place. No one we met required care plans presented in an accessible format; however staff shared previous examples of supporting people with cultural, sexual and religious needs. Staff told us they knew who had hearing or sight impairment and would speak in people's good ear and check their hearing aids for batteries. Staff made sure they did not move people's belongings around in their home so they could easily find them. One staff told us she always knelt down at a person's level so they could see her as they spoke and ensure they understood and heard them.

Requires Improvement

Is the service responsive?

Our findings

The service undertook their own assessment of people's strengths and needs. This assessment process also helped to clarify information received from the referrer, and identify if staff required further training before they were able to support people. If people were coming into the community from a residential or family home setting, the service ensured all the necessary housing and equipment requirements were in place and the transition went as smoothly as possible.

Support plans were then developed based upon people's needs. We found these required greater information and details to reflect people's individual physical, emotional and social needs. For example one person we met and whose care plan we reviewed had recently had their second leg amputated. Their care record had not been updated promptly to reflect this or reflect the potential emotional impact this might have had on them or their family who lived with them. However, all staff had been informed by a memo of these changes and were aware. The manager told us this had been delayed to allow the person to adjust to being at home again and was updated following the inspection. Support plans required more detail about people, their history, professionals involved and their preferences for care and support. Where people had mental health needs there was little guidance in place to guide staff how to support them or who to contact if they were concerned. Another person had diabetes and the support plan did not describe the role staff took in assisting the person or action they should take in the event the person had high or low blood sugar. The manager told us care plans were in the process of being updated but the ones we viewed were inconsistent and lacked detail to guide staff.

All staff knew people's routine and their preferences well. People and relatives confirmed these were respected. However, some people's support plans were not written in a person-centred way describing people's preferred routine. Staff we spoke with clearly knew people very well. Detailed support plans would provide clear guidance and direction for staff about how to meet a person's needs, their likes, dislikes and routines. We discussed with the management team how support plans might include information for staff about how people liked their personal care delivered and how to communicate with people if they had hearing or sight difficulties. People's preferences in relation to what they liked to be called, or if they had a preference for staff gender for personal care, waking times and how they liked their tea in the mornings were all areas for improvement to ensure consistency across support plans and reflect individualised care. People's goals were not recorded, so it wasn't clear what these were, whether they had achieved these or what interventions required to support people to achieve their goals.

Some people receiving a service were older adults. The service had supported people at the end of their life. However, the care plans we reviewed lacked information relating to people's wishes at this stage of their life. The management team told us they would update all care plans to include this information but they were mindful this was a delicate subject. However, staff gave examples of caring for people at the end of their lives, how they had previously met people's cultural needs in relation to their death and a card and some forget me not flower seeds were always sent. Staff often attended the funeral where they were close to people and rotas could be rearranged.

Accurate records were not always kept. This is a breach of Regulation 17 of the Health and Social Care Act (Regulated Activities) Regulations 2104.

If people had protected characteristics under the Equality Act the registered manager assured us the provider's policies reflected people be treated equally and fairly.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. We spoke with the office manager, registered manager and senior staff about further enhancing the information in support plans, reviews and information guides so if people wished to have copies of their care and support plans in an alternative format these were in place. They told us this was already possible if people wished.

We reviewed the concerns and complaints which the service had received in the past 12 months. These had been responded to promptly and investigation occurred where required. Feedback had been given to the complainant and meetings arranged to discuss situation further where required. People and relatives confidently told us they had no concerns during the inspection but if they did they would know who to contact in the office. Information was also available for people about the complaints process in their service user guide book. We fed back to the manager of the service that we had received information which indicated not all people were aware of the process. they intended to discuss this with people using the service.

Requires Improvement

Is the service well-led?

Our findings

The provider was a longstanding, family run business. The service was run by the provider alongside the registered manager with the support of an office team. Approximately 40 staff were employed on permanent contracts.

The nominated individual, registered manager and office manager supported the inspection. They told us their goal of the company was for, "People to be able to live in their own homes for as long as possible despite disability, age, gender, faith or their culture." Conversations we had with the nominated individual and registered manager demonstrated a supportive, close knit team. There was a clear staff structure in place and staff knew their roles and responsibilities. The provider visited three times a week and told us they reviewed staff files, people's files and risk assessments. They talked with the registered manager and manager about any issues arising. The management team all told us, "We have an open door policy – staff pop in, and have a chat and a cup of tea." Staff we spoke with all confirmed a friendly atmosphere at the office and they told us the management team were approachable and responsive to any problems they might have.

During the inspection we found the provider's governance arrangements had not identified that care plans and risk assessments lacked sufficient detail and depth to guide staff to care for people in a personalised way. Staff relied on asking and knowing people well. The lack of travel time meant people were not always receiving their allocated, paid time. This had not been identified as an issue through the provider's governance and quality assurance systems. Staff we spoke with and people mentioned the communication between the office and staff could be improved, for example one staff member they weren't always informed when a person had passed away or had gone into hospital. The manager told us they were not always made aware when people had been admitted to hospital though. We spoke to the registered manager about these areas and they intended to act upon inspection feedback and use this to drive improvement in these areas.

The registered manager promoted the ethos of honesty, learned from mistakes and admitted when things had gone wrong. This reflected the requirements of the duty of candour. The duty of candour is a legal obligation to act in an open and transparent way in relation to care and treatment. Inspection feedback was listened to and plans were in place to improve care plans and auditing of these, build in travel time between visits, and look at how communication between the office, staff and people could be further enhanced.

The management team were motivated and positive about the future. The visions and values of person centred care and inclusion were shared across the staff team. New quality assurance feedback was being obtained each month based on the Commission's five key areas, Safe, Effective, Caring, Responsive and Well-Led. The results of the questionnaires had not yet been analysed but we saw action had already been taken to address minor issues which had been fed back through this quality assurance process.

The registered manager and senior staff were hands on. They explained they wouldn't ask any staff to do anything they themselves were not happy to do. The registered manager covered at times of staff sickness and when required, knew people well and told us, "We are hands on and it makes a difference." This helped

them know people's care and staff challenges in the community. All people and relatives we spoke with knew and had confidence in the registered manager.

Staff who worked for the company were valued and cared for by the provider. The effort staff had made during the winter snow was appreciated and a crate of wine had been purchased for staff. Another staff member had been unwell with cancer and the company had helped her create a "bucket list" of things she wanted to do. The management team and senior staff told us, "We work as a family, a team and look out for each other."

Policies and procedures were in place to help ensure the service was well run. Checks were undertaken on people's homes, medicine, training needs and new staff. The service stayed abreast of changes, for example the changes in the law related to General Data Protection Regulations (GDPR).

Care was provided by a service which listened to feedback and responded to change where required. For example, the registered manager shared how all communication was now shared on the computer to ensure people's feedback was acted upon. This meant there was a clear record of conversations and decisions made.

Feedback was obtained from people, their family and professionals. This helped ensure on-going improvement to the service. Feedback we received from people, relatives and staff was responsive. Individual and staff concerns we fed back during the inspection was listened to and we were confident action would be taken by the registered manager to remedy these areas for example travel time, rota's and better communication between the office and staff.

An external trainer was employed to work alongside the management and staff team two days a week. They monitored and deliver staff training and were supporting the company to develop data protection policies. Local forums and training events which discussed best practice were attended by the external trainer who provided feedback to the management team and staff.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance Good Governance Regulation 17 (1) (2) (c) Accurate, complete and contemporaneous records were not always kept.