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Islington - London

Inspection report

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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?	**Good**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

This inspection was undertaken on 27 September and 1 October 2018 and was announced.

Islington – London (also known as Blue Popies Care and Support Services) is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults as well as people with physical and mental health conditions. At the time of our inspection there were 8 people using the service receiving the regulated activity of personal care.

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 and associated Regulations about how the service is run. The registered manager was also the owner and had been managing it since it was founded in 2014.

During this inspection we found the service provided good quality support and people's needs had been met effectively. Staff were appropriately trained and the registered manager had been personally involved in care for each person using the service. We saw examples where care provided by the agency went beyond the usual contractual duties. This was to ensure that people received complete support and to make their life more comfortable.

We also found that some areas of the service required improvement. This was because care and support provided by the service had not been fully meeting the current guidelines and the Health and Social Care Act Regulations. We discussed these shortfalls with the registered manager who was receptive to our feedback.

The registered manager had systems in place to monitor the quality of the service and they maintained them regularly. However, these had not always identified the shortfalls we saw at this inspection.

At our previous inspection in April 2016 we found some issues with the management of risk to the health and wellbeing of people who used the service. At this inspection improvements were noted in how the agency managed individual risks to people. However, further improvements were needed to ensure information about all risks were personalised.

At this inspection we found that the agency had not always managed people's medicines according to the current guidelines. We could not always say what medicines were prescribed to people and if people had received them as intended by the prescriber. Therefore, there was a risk that people could receive their medicines in unsafe way.

Staff understood their role in safeguarding people and people were protected from harm from others. The registered manager was taking proactive action when they thought people were at risk of harm.

There were further systems in place to ensure people were safe. Accidents and incidents were managed proactively and action was taken to reduce their reoccurrence. There were sufficient staff deployed to ensure people's needs were met. Safe recruitment procedures protected people from unsuitable staff. Effective infection control measures used by staff protected people from avoidable infection.

Staff had appropriate skills and training to meet people's needs. The registered manager had provided ongoing formal supervision and informal support to ensure staff cared for people in an effective and safe way.

Staff helped people to have a nutritious diet that met their health needs and preferences. People had access to healthcare professionals when their needs had changed or their health had suddenly deteriorated.

The agency worked within the principles of the Mental Capacity Act 2005. People had been asked for their consent before staff provided any care to them.

People using the service thought staff who visited them were kind and caring. People said they felt respected when receiving personal care. Staff encouraged people to be as independent as they could and supported people in living a comfortable life in their home and in the local community.

People's care needs and preferences had been assessed by the agency before they started providing care to people. Staff supported people with respect to their changing needs and individual preferences. Some improvements were required to ensure information about changes to people's care needs could be found easily by staff who supported people.

The agency had a complaint procedure in place and it was known to people. People told us they had no reason to complain. However, they were comfortable to speak to the registered manager if they had any concerns.

At the time of our inspection the agency had not provided end of life care. However, we noted that previously the agency had provided end of life care. We saw compliments from relatives, who were thankful about the support their loved ones had received.

Stakeholders spoke positively about the service provided by the agency. People using the service and their family members said they would recommend the agency to others. Staff felt supported by the registered manager who they could contact at any time with any issues. External health and care professionals felt there was good communication with the agency and they felt the agency could provide appropriate support to people even those with the most complex needs.

We found two breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We have made one recommendation related to risk management. 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

Some aspects of the service were not safe.

People's medicines were not managed according to the current guidelines. Therefore, there was a risk that people might not receive their medicines in a safe way.

Further improvements were needed to how the agency personalised and recorded information about risks and risk reduction strategies to health and wellbeing of people who used the service.

People said they felt safe with staff who supported them. Staff understood their role in protecting people from harm from others. There were systems in place for management of accidents and incidents. Appropriate recruitment procedures protected people form unsuitable staff.

There were systems in place to ensure appropriate infection control.

Is the service effective?

Good

The service was effective.

People's care needs and preferences had been assessed before they started receiving support from the agency.

Staff were provided with training and ongoing supervision to ensure they supported people in a safe and effective way.

People were supported to receive a nutritious diet that met their health needs and personal preferences.

Staff supported people to have access to health professionals when their needs had changed or their health suddenly deteriorated.

The agency had worked within the principles of the MCA 2005. Staff asked for people's consent before providing care.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who aimed to make people's life more comfortable.

People felt involved in planning and reviewed of their care. Staff encouraged people to be as independent as they could.

Staff respected people's privacy and dignity when providing personal care to them.

Is the service responsive?

Good

The service was responsive.

People received care that was person centred and had taken into consideration people's changing needs and individual preferences.

People had access to the complaints policy, however they told us they had never had the reason to complain about the service they had received from the agency.

The agency was not providing end of life care at the time of our visit.

Is the service well-led?

Requires Improvement

Some aspects of the service were not well led. This was because, although the service had systems to monitor the quality of care, these were not always effective.

People gave positive feedback about the leadership and the agency and they said they would recommend it to others.

Staff thought the agency was well led. Staff said they could contact the registered manager at any time and they would be supported.

People and staff were encouraged to give their feedback about the agency.

Islington - London

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was undertaken on 27 September and 1 October 2018. We gave the provider 48 hours' notice that we would be visiting their head office. We gave the provider notice as we wanted to make sure the registered manager was available on the day of our inspection.

This inspection was carried out by two inspectors, and one 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 our visit to the head office, we spoke with three people who used the service and one relative.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed PIR and previous inspection reports before the inspection. We reviewed other information we had about the provider, including notifications of any safeguarding concerns or other incidents affecting the safety and wellbeing of people.

During the inspection, we spoke with the registered manager who was also the agency's owner.

During the inspection we reviewed five people's care records, which included care plans, risk assessments and Records of Medication Administration (RMA). We also looked at four staff files, complaints and quality monitoring and audit information.

Following our visit, we contacted a number of health and social care professionals who worked regularly with the agency. We received feedback from three of them.

Requires Improvement

Is the service safe?

Our findings

The majority of people who used the service managed their own medicines, or family members did this. Staff administered medicines to three people and we looked at how the agency managed medicines for all three of them.

Records showed that staff had received training in safe medicines management. Staff we spoke with knew guidelines around medicines management provided by the agency and they followed it. Records showed that staff had recorded all medicines administrations. The registered manager told us, they had regularly audited relevant records to ensure they were completed correctly. However, we found that the agency's current medicines management procedures and therefore staff practice had not been in line with current formal guidelines and recommendations for supporting people in the community.

The majority of medicines administered by staff were given to people from pre-prepared blister packs. We saw that staff had recorded each medicines administration on Records of Medication Administration (RMA) forms. Staff signed the RMA after administration to show that medicines were given. This assured us that medicines were given as prescribed and were available. The form included information on the date, the time the medicine was administered and which staff administer it. However, the RMA did not list all medicines prescribed to people as well as its strength, frequency of administration and the route of administration. The records also did not have specific details about the person, such us, their date of birth, GP's details, any allergies and any additional information or specific instructions for giving the medicines. This is what is recommended by National Institute for Clinical Excellence (NICE) in their guidelines: "Managing medicines for adults receiving social care in the community, March 2017". The guidelines were introduced to ensure people received their medicines effectively and safely at home. Furthermore, there were no current medicines list available for people in their files during our visit. This meant staff were not able to verify if there were any changes to medicines or for any mistakes made during blister pack preparation. Therefore, there was a risk people would receive medicines in unsafe way and not as it was intended by a prescriber.

We identified that each person who was in receipt of a "when required" (PRN) medicine, did not have a PRN care plan. A PRN plan details the medicine, dosage, expected outcome and if there are any interactions with the regular medicine. The fact this was not in place, meant staff did not have sufficient information on medicines they administered.

Some people who were prescribed creams did not have a topical medicines administration chart in place (TMAR) to record time and frequency of application. There was no detailed information including a body map to show care workers where application was needed.

The above is evidence of a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

At our previous inspection, in April 2016, we found that risk related to specific aspects of people's care had not always been assessed. Following our inspection, the reregistered manager provided us with an action

plan in which they stated action would be taken to address this matter. At this inspection we found this issue had been partially addressed.

Risk assessments had been carried out in three strands. These included a client health and safety assessment checklist, a risk control and action form and a generic risk assessment. The risk control and action measure form was a tool introduced by the registered manager following our previous inspection. This included information on risks related to individual health conditions, behaviours or other specific risks identified. The document provided staff with information and actions to take to reduce the risk of an accident, albeit not as detailed. For example, one person had difficulty with mobility during a specific activity. The control measure advised staff to, "make a referral to the external professional to consider various safe options to support the person". However, there was no specific direction on what to do to keep the person safe. We discussed this with the registered manager, who acknowledged the need for more comprehensive risk assessments.

We saw that each person also had a generic risk assessment related to various aspects of care not identified on the individual risk control and action form. These included manual handling, handling of medicines or infection control risk assessment. We noted that these documents were detailed in information about potential hazards and possible risk control measures. However, because they were generic they did not reflect specific issues around highlighted risks for each individual.

We also saw that some risks had been identified and staff were given information on how to provide safe care. However, this information was not always provided in the form of a risk assessment document but recorded in the person's care plan. This meant there was some inconsistency on where this important information could be found by staff supporting people.

From our discussions with the registered manager and staff we found that they had good knowledge of individual risks to people and they knew how to support people safely. Various correspondence with people, their relatives and external professionals indicated that the agency had been proactive in raising concerns and seeking additional support when new risks to people's health had been identified. People we spoke with did not raise any concerns around safety when receiving care. External professionals also did not express any concerns and they felt staff knew how to support people safely. However, lack of detailed information related to people's risk meant there was a risk that people may receive inconsistent care.

We recommend that the agency seeks further support and advice from a reputable source of effective risk assessment and risk management planning that is in line with current good practice guidance.

We discussed all above findings around the risk assessment and management with the registered manager during our visit and they were open to our feedback.

Staff also carried out an environmental risk assessment of people's homes. This included areas such as trip hazards, pests and parasites, use of chemicals, electrical safety and gas safety, work equipment (hoists) and fire safety.

The agency had processes and procedures around accident and incident management and staff knew them. We saw that when an accident and incident occurred staff had completed an incident report and submitted it to the registered manager for their review. We saw that appropriate action had been taken by the agency to reduce the possibility of further accidents and incidents reoccurring. However, we noted that the agency had not informed us about on incident as it is required by the law. We are looking into this matter further.

People using the service told us they felt safe with staff who supported them. Two people told us, "Yes, I feel safe with my carers". A family member said, "I am so happy with this service and the whole family is really relieved to have a good care system in place." Records showed that staff had received training in safeguarding adults. All staff we spoke with had a good understanding of their responsibilities around protecting people. They knew what action they needed to take if they thought somebody was at risk of harm from others. One staff member told us, "Safeguarding means keeping people safe in their environment and from abuse from others. If I had any concerns I would inform my manager, safeguarding authority, CQC or the police." Another staff said, "We cannot restrain people from doing things we think are unsafe for them. If they have capacity we have to accept their choice. However, we have to protect people from abuse from others."

The agency had a safeguarding policy and it was available for staff to view. Records showed that there was an ongoing communication between staff and the registered manager about people and their safety. We saw that when people were at risk the registered manager had made prompt alerts to the local authority and respective health and social care professionals to ensure appropriate action was taken and people were protected. We saw that when concerns had been raised by external professionals, the agency had worked closely alongside of those professionals to ensure any safeguarding concern had been looked into and people were safe. We saw that the registered manager maintained comprehensive records or any action that had been taken in relation to any safeguarding matters raised. However, we noted that the registered manager had not informed the Commission about three safeguarding concerns. This is required by the Regulations.

The agency had not recruited any new staff since our last inspection. During our pervious inspection, in April 2016, we assessed that the agency's recruitment processes were safe. Therefore, we did not look into this matter during this visit. However, we checked if the registered manager had carried out repeated and appropriate criminal checks for existing employees to ensure people were protected from unsuitable staff. We saw that all staff had criminal record checks completed as required. Additional protective measure had been introduced by the registered manager. All staff were required to complete a yearly criminal convictions declaration form (CCDF). The registered manager explained this was introduced so staff could take responsibility for informing the agency if their criminal checks status had changed. An annual service monitoring form maintained by the registered manager showed that they monitored CCDF to ensure they were completed.

People told us staff had attended scheduled calls as agreed. They said, "They do their best, they are not always on time, but they do ring and let me know" and "They are always on time and if they are ever going to be late I am always kept informed." Records showed that there were sufficient numbers of staff allocated to support people. We saw that suitably completed staff rotas ensured all calls were covered as required. Other records seen by us indicated that the registered manager increased staffing levels and the length of calls to ensure people were appropriately supported during the time of increased care needs. A person using the service confirmed there was always enough staff to support them. They said, "The carer comes [number] times a day and sometimes there are two people at the same time."

Staff received training in infection control and they were provided with appropriate personal protective equipment (PPE) to ensure staff and people were protected from avoidable infection. Staff confirmed they received appropriate training and they knew how to reduce the risk of cross infection. They told us, "Yes I had a training. I always wear gloves, apron and sometimes a mask. I wash my hands and I follow seven steps to ensure my hands are clean" and "Always wear gloves and apron that I receive from the manager". A person using the service confirmed staff followed infection control measures. They told us, "Yes, they wear gloves when washing me."

Good

Is the service effective?

Our findings

People's care needs and personal preferences had been assessed before they received support from the agency. We saw a pre-admission and pre-care planning documents in people's files. This included assessment of people's healthcare needs, what their care preferences were and how they would like to be supported. People confirmed that prior to receiving support, they were visited by an agency representative to discuss their needs.

Staff told us and records confirmed that staff had been trained to meet people's care and support needs. Training records showed staff had received essential training in areas, such as, Safeguarding, Mental Capacity Act 2005-supporting decision making, Safe management of medication, health and safety, nutrition and hydration, moving and handling, dementia, record keeping, hygiene and infection prevention and control. We saw that the training had been provided within the last 12 months.

There was no new staff employed by the agency since our last inspection. Therefore, none of the staff had to undergo a new employee induction. However, the registered manager told us, and staff confirmed, they had received an induction to every new care package before they supported people unsupervised. The registered manager said, staff shadowed experienced members of staff until they felt confident to provide care on their own. A staff member told us, "We have an induction when we start working with a new person. Especially if the person has complex needs." Records confirmed that such inductions were taking place.

Records showed that staff had received regular supervision. The registered manager told us, the frequency of supervision varied, depending on the level of workload of each individual staff member. We saw that areas covered during the supervision included relationships with people using the service, relationships with colleagues and any areas of concern. Through our conversation with the registered manager and care staff we found that they were in constant contact to discuss care for people and any related matters. This formed the basis for an ongoing, informal supervision. There were also other tools used by the registered manager to monitor and support staff. These included unannounced care worker spot checks and care worker onsite observations. Staff confirmed that they had received regular supervision and they felt supported in carrying out their role effectively. They said, "Yes I have frequent supervision. The manager likes to check if I am having any difficulties" and "Yes, I receive supervision. The manager also calls me out for a meeting if I have any issue with a person using the service." Records showed and staff confirmed that they had received yearly appraisal of their skills. We saw that the appraisals were linked to the key care standards and organisational goals. This meant they were relevant to the work staff carried out and were in line with what the agency wanted to achieve as a care provider.

Where it was care planned, staff supported people to have a nutritious diet that suited their dietary needs and personal preferences. People's care plans had a detailed description of what people's food likes and dislikes were and how staff were expected to provide the support during mealtimes. For example, staff were asked to cut a person's food in small pieces as the person was not able to do it. People's special dietary needs related to their health conditions, such as diabetes or difficulties with swallowing, had been recorded in people's files. Staff were provided with information on food preparation and feeding techniques to ensure

they supported people safely. We also noted, the emphasis had been put on ensuring people were sufficiently hydrated. Staff were reminded to encourage water and fluids and to place drinks near people so they could reach it when staff were not present.

We identified numerous pieces of evidence from the records of the agency working closely with other professionals to ensure people received effective care. We saw that the registered manager was proactive in informing respective professionals of any changes to people's health and ensuring appropriate referrals had been made so people's changing needs could be met.

Prompt action had been taken by staff when people's health suddenly deteriorated and they needed immediate attention from health services. A family member told us, "The care staff recently turned up and found my relative unwell. They responded and called an ambulance straight away."

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.

The agency had an MCA policy in place to guide staff on matters related to supporting people with no or limited capacity. Staff had received training in the MCA. Both, staff we spoke with, and the registered manager could tell us about the key aspects of the legislation. Staff comments included, "We talk to people and we ask for their consent. We need to respect their wishes" and "People with no capacity can make some decisions. You need to involve and encourage people to make their own decisions."

The majority of people receiving support from the agency had capacity to make decisions. Where people did not have capacity or if there were concerns around their ability to make decisions, appropriate, supportive action had been taken by the agency. The registered manager told us, and records confirmed, they would discuss people's capacity with appropriate health and social care professionals and people's relatives. This was to ensure any decisions made on people's behalf were made in their best interest.

A consent form was a part of the standard documentation in people's files. People had signed up to care by stating they had agreed with the care plan, which had been drawn to up to meet all their individual needs. They signed to confirm they had participated in the process of creating the care plan. Other documents in people's files, showed staff had obtained consent from people before they could proceed with any task at hand. In one person's file we read, 'I have been given permission by the above-named individual to contact you on his behalf and request if it will be possible for him to have an urgent re-assessment of his needs'.

Good

Is the service caring?

Our findings

People told us they felt they were supported by staff who cared for them. They told us, "Yes, I feel that my carer is kind and caring", "The carers are always kind and caring and engage me in conversation. They make sure they have time for cups of tea with me and are good at conversation". A relative told us, "The staff are always kind and caring and most importantly my [relative] is happy."

Staff spoke kindly about people they supported and they said one of the main motivators to care for people was to make people's life more comfortable. One staff told us, "It can be very rewarding when I can help and support people." Two other staff members told us they worked for the agency as they enjoyed caring for people.

We saw that the agency had received a high number of compliments from people who used the service, their family members and external health and social care professionals. These were usually related to praising staff for their good service, additional support provided to people or simply staff's caring and compassionate nature. Some of the compliment notes stated, "I truly feel that God blessed me with [staff name] as a carer" and an email to two staff members "You both went above and beyond the call of duty and it was gratefully appreciated by me and by [a person using the service]". An external social care professional stated, "[staff name] did an excellent job. [person using the service] looked really well and staff went over and above. She is a great carer."

All people we spoke with and their relatives told us they felt involved in planning and reviewing of their care. They confirmed the registered manager had visited them regularly to discuss their needs and satisfaction with the service provided. One person said, "[The manager] visits to review my care needs". A family member told us," I feel very involved in my relative's care. I feel that my point of view is really listened to by the service." Staff we spoke with were able to give us examples of how they empowered people to be involved in their care and to be as independent as they could. One staff member told us, "If I think a person can do something I will encourage them to do it", "When I shower people, I let them do what they can and I guide and support them with it" and "I will give a person a cup so they can drink it themselves."

Records showed that staff had received training in equality and diversity. All staff we spoke with showed their understanding around working with different religions and cultures from their own. They also told us the information about people's background and what was important to them was explained by the registered manager before staff visited people for the first time. They told us, "I am always introduced to people and the office always informs me about people's background before I visit them. They would not just send me there without discussing it first" and "People come from different cultures. When it comes to different aspects of their care, for example food, you need to respect that and provide to people what they want."

Records showed that the agency supported people as much as they could and often beyond providing regular personal care. We saw examples of email communication between the registered manager, people using the service and external professionals about supporting people with purchasing furniture for their

home or setting up an IT equipment so people could use it safely. Staff told us how they supported people with doing things they liked and enjoyed as well as with attending formal appointments. This included supporting people to go for walks, access the gym, have breakfast or lunch in the community, watch a film in the cinema or attend scheduled medical appointments.

People told us that staff respected their privacy and dignity when providing personal care. They said, "They deal with my personal care and they are always respectful" and "[staff name] show respects when she washes me." We saw that people's care plans had detailed information on what personal care was required and how people would like to receive it. This, for example, included information on which tasks staff should support a person with and which tasks they could carry out themselves, what type of toothbrush they had been using and what type of clothing they slept in. Staff we spoke with showed understanding around the sensitive nature of providing personal care to people. They told us it was important to ensure people felt comfortable. One staff member told us, "I always cover a person with a towel and I explain anything I do to her. This was she understands what I am doing" and "When a person is using a toilet I wait outside for them to call for help. This offers them some dignity." Another staff member told us, "I always cover people so they are not cold and exposed. A lot of time I do personal care a part of routine, but I always ask people how they would like personal care to be done."

Good

Is the service responsive?

Our findings

We found that the agency provided person centred care and had taken into consideration people's care needs and individual preferences. All people we spoke with and their relatives were positive about the support they received. Some of their comments included, "I think this care company does such a good job considering my relative's complex needs", "I look forward to their visits and they really do their best, I completely trust them" and "The carers are lovely. The manager is lovely."

External health and social care professionals also felt the care provided by the agency was proactive in addressing people's changing needs and it was tailored to people's individual preferences. One professional told us, "The timely and accurate feedback received [from the agency about a person using the service] allowed appropriate support to be put in place and equipment ordered to prevent [further risk to the person's wellbeing]." Another health professional described to us how staff from the agency skilfully supported a person with full consideration of the person's chosen lifestyle, developed habits and complex needs.

We found that when possible people were supported by the same care staff. This indicated there was a continuity of care which helped to develop friendly and positive caring relationships between people and their care staff. Staff we spoke with and the registered manager knew people they supported well. They were able to describe to us people's needs, their individual preferences and chosen ways of living.

We found that people using the service had a core care plan that had a description of people's care needs and personal preferences. This included information on how people wanted their care to be provided, their personal likes and dislikes and any equipment people used to support their care. Care plans also had a description of additional tasks that were not directly related to providing personal care. However, these tasks carried out by staff to ensure people lived a comfortable life. This, for example, included housekeeping tasks, shopping or help with attending appointments and access to the local community. Staff told us care plans were easy to follow and they felt they had sufficient information to care for people effectively.

We saw that people's care had been reviewed regularly. However, we noted that the agency's system around recording changes to people's care was not always effective in ensuring that this information could be found easily. Records showed that people's care needs had been reviewed yearly. These reviews had been recorded on "service review forms". We saw that these were done regularly and consisted of details of people's most current circumstances. If people's needs had changed prior to the formal review, we saw that a proactive action had been taken by the agency to ensure people received care that reflected their needs. Information about these sudden changes had been well described in various documents, such as, correspondence with other professionals or email memos from the registered manager to staff. We saw that communication between the agency and external health and social care professionals and about people's care had been ongoing. Therefore, we were reassured that people had been receiving support that matched their needs. However, because the information had been fragmented between various documents and not transferred into people's core care plan, there was a possibility that an important detail about people's care would be missed by staff who supported them.

Since our last inspection in April 2016 the agency had not received any formal complaints. There was a complaints policy that had been available in care files in people's homes. All people we spoke with told us they knew how to make a formal complaint. They also told us that they had never had to make a formal complaint as they felt comfortable with raising any concerns with the registered manager. Some of people's comments included, "I would feel very confident to make a complaint if I had one but I don't have any", "The agency does its best, the manager is approachable and has been around to the house, I have no complaints" and "I would not have any problem complaining if I was unhappy, but I am happy."

At the time of our inspection, the agency had not provided end of life care to any of the people who used the service. However, compliments received by the agency from family members and external professionals showed positive feedback about previous support offered to people shortly before they passed away. The feedback had highlighted caring and committed nature of staff employed by the service. For example, a family member wrote, "Thanks for all support in this case. It made a difference in the short time that we had left [with our relative]. In another example a healthcare professional wrote, "[staff name] has been exceptional with [person's name] through the whole time I have known Ms [person's name]. Making someone's last days comfortable is one of the most important and valuable things someone can do for someone."

Requires Improvement

Is the service well-led?

Our findings

During this inspection we found that, the agency provided quality care to people who used it. However, we observed there was no clear governance arrangements in place to ensure all aspects of the service were provided in line with the current guidelines and the Health and Social Care Act 2008 Regulations. We saw that the quality monitoring audits used had failed to identify the gaps in the service delivery we had identified at this inspection. Therefore, the agency required development to adhere to current standards of good and safe practice.

The issues we identified included failures in the management of medicines. The agency did not have effective systems in place to support the reporting of notifiable incidents as required by the Regulations. Consequently, the agency had not informed the Commission about a number of notifiable events. We are looking into this matter further. We saw that the agency did not always follow a specific system to ensure they kept accurate, complete and contemporaneous records in respect of each person using the service. Therefore, information about people's care was spread across various document in people's care files. The agency had policies and procedures in place to guide staff on how to support people. However, there was no clear evidence that these had been reviewed regularly to match most current guidelines and the Regulations.

The above is evidence of a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also saw good examples of systems used by the registered manager to monitor the service quality. We saw that these included a staff supervision and training tracker as well as annual monitoring forms for staff details and people's care files. We saw that although annual monitoring forms were designed to be updated yearly, the registered manager had checked and updated them monthly. They told us they wanted to ensure that all information updated as soon as any changes had been identified.

People using the service and their family members, spoke positively about the service provided by the agency. They told us they would recommend the agency to others. They said, "I can't fault the agency" and "I know the manager well, she is very approachable." A family member told us, "The manager is really approachable. I have no problems contacting her if I need to. She always replies very quickly to any text or email that I send."

Staff employed by the agency told us they felt supported by the registered manager at all times. They said, "I like the manager. I can call her any time. If I need something form the office the manager will bring it to the person's home", "The manager looks out for me. I can call her any time. If I have any issues or request she will follow it up." We noted that the staff turnover at the agency was very low and most employees had worked at the agency since it was founded. This indicated staff were satisfied with their employment.

External health and social care professionals also spoke positively about the management and the service provided by the agency. One professional stated, "I have witnessed a clear and effective chain of command,

good communication between staff and head office and a willingness of Blue Popies management to personally follow up any issues raised when necessary." Another professional told us, "Blue Popies does not wait for the due review process to take place – it highlights issue(s) that need addressing in a very timely manner."

People were encouraged to provide their feedback about the care provided. The agency carried out a yearly quality assurance service user survey. The survey was categorised into consistency in care, care worker professionalism, quality of service provided, communication with Blue Popies and support services. We found that the overall feedback from people was positive. The registered manager also carried out quality assurance visits to check if people were happy with the service received. Records showed that these visits were carried out every quarter. Furthermore, we saw emails confirming that the registered manager was in constant contact with people. Therefore, the feedback about the care received could be provided at any time.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The registered person did not ensure care was provided in a safe way for service users because: They had not ensured the safe and proper management of medicines. Regulation 12 (2) (g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The registered person did not operate effective systems to: Assess, monitor and improve the quality of the service against Regulations 4 to 20 A of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014. Regulation 17(2) (a) Maintain contemporaneous record in respect of each service user Regulation 17(2) (c) Evaluate and improve their practice to ensure that their audit and governance systems remain effective. Regulation 17(2) (f)