Nestor Primecare Services Limited

Allied Healthcare Newcastle

Inspection report

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Ratings

Overall rating for this service	**Requires improvement**
Is the service safe?	**Requires improvement**
Is the service effective?	**Requires improvement**
Is the service caring?	**Good**
Is the service responsive?	**Requires improvement**
Is the service well-led?	**Good**

Overall summary

This inspection took place on 1, 3 and 10 September 2015 and was announced.

We last inspected this service in February 2015. At that inspection we found the service was not meeting all its legal requirements. One breach of regulations was found, relating to the safe management of medicines.

Allied Healthcare Newcastle is a domiciliary care agency that provides personal care to adults and older people, some of whom may have a dementia-related condition. It does not provide nursing care. It provides support to approximately 480 people in the Newcastle upon Tyne area.

The service did not have 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

Summary of findings

the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A manager was in post, and this person had applied to be registered with regard to this service.

The service was not always ensuring people's safety with regard to the administration of their medicines.

Staff were fully aware of their responsibilities for safeguarding vulnerable people from abuse and had been given the necessary training to recognise and report any potential abuse. Where there was any suspicion that a person had been harmed, this was reported immediately to the proper authorities. Risks to people using the service were assessed and steps were taken to ensure people's safety.

There were enough staff to meet people's needs, and steps were being taken to recruit more staff and improve the reliability of weekend calls. Robust systems were in place to ensure only suitable new staff were recruited.

People's healthcare needs were monitored closely and any concerns were reported to their GP. People's food and drinks preferences were respected and any religious, cultural or health needs related to diet were recorded and included in the person's care plan.

Staff had been given the training they needed to provide people with effective care. People told us they were happy with the skills and knowledge of their regular care workers. Staff were supported by regular supervision and appraisal of their work.

People told us their care workers were careful to ask for their permission before carrying out any personal care. However, we found the formal recording of consent to care was poor. No assessment had been carried out to ensure people had the mental capacity to make informed decisions about their care. This meant the service was not complying with the Mental Capacity Act 2005.

People told us their care workers were kind and caring, and they had established good relationships with their regular workers. People said they were treated with respect and their privacy and dignity were protected. They said they were encouraged to be as independent as possible.

People told us they were given sufficient information about their service and their rights. They said they were given the opportunity to comment on the quality of their service in surveys and reviews.

People's needs had not always been properly assessed and their care plans were not fully personalised. The provider had introduced new systems to address this issue, but these had not yet been extended to everyone using the service. Care was taken to identify and address issues of social isolation.

Complaints were treated seriously and properly investigated and acted upon. Systems were in place for the auditing of the quality of the service.

The service had a new manager who had applied to be registered with the Care Quality Commission. The manager demonstrated good leadership and was introducing new systems to improve the service offered to people.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These related to the safe administration of people's medicines, obtaining people's informed consent to their care, and giving person-centred care. You can see the actions we have told the provider to take at the back of the full version of this report.

Summary of findings

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

The service was not always safe. The service was failing to protect people using the service against the risks associated with the unsafe use and management of medicines.

Staff were trained to keep people safe by recognising and reporting any suspicion of abuse.

There were enough staff to meet people's needs, and recruiting systems were robust.

Is the service effective?

Requires improvement

The service was not always effective. People's rights under the Mental Capacity Act 2005 were not always respected.

Staff received appropriate levels of training, supervision and appraisal.

People's health was monitored and any concerns were reported and acted upon.

People's dietary wishes and needs were met.

Is the service caring?

Good

The service was caring. People told us their care workers were kind and caring, and treated them with respect.

People told us their privacy and dignity was protected at all times.

People told us they were encouraged to be as independent as possible.

Is the service responsive?

Requires improvement

The service was not fully responsive. People's needs and preferences regarding their care had not been fully assessed and their care plans were not always person-centred.

Complaints and concerns were taken seriously and properly investigated.

People were supported to prevent them becoming socially isolated.

Is the service well-led?

Good

The service was well led. The manager provided good leadership and clear expectations, and was committed to ongoing improvement of the service.

Systems were in place to monitor the quality of the service.

People told us they were asked their views about the service, and said they felt the service had improved.

Allied Healthcare Newcastle

Detailed findings

Background to this inspection

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

This inspection took place on 1, 3 and 10 September 2015. The inspection was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the provider's representative was available to assist us with this inspection.

The inspection team was made up of one adult social care inspector, an expert-by-experience, and a specialist advisor. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider about significant issues such as safeguarding, deaths and serious injuries the provider is legally obliged to send us within required timescales.

We contacted other agencies such as local authorities and Healthwatch to gain their experiences of the service. We received no information of concern from these agencies.

During the inspection we talked with 18 people who used the service by telephone and two relatives. We spoke with staff, including the manager, the Care and Delivery Manager, training officer, four care co-ordinators and administrative staff, and four care workers. We 'pathway tracked' the care of three people, by looking at their care records, visiting them in their homes and talking with them and care assistants about their care. We reviewed a sample of 10 people's care records; six staff personnel files; and other records relating to the management of the service.

Requires improvement

Is the service safe?

Our findings

At this inspection we found some improvements had been made since the last inspection regarding medicine management. However we considered that the service was still failing to protect people against the risks associated with the unsafe use and management of medicines.

During this inspection we looked at the medicine records of 14 people who used the service. We spoke with staff about medicines and reviewed the provider's medicines policies. Of the 14 medicines records we looked at, we visited six of the people in their own home to make sure that appropriate arrangements were in place to manage medicines safely.

Arrangements did not always ensure that the administration of people's prescribed medicines was accurately recorded. We saw that the forms which care workers signed to record when people had been given their medicines did not always clearly demonstrate exactly which medicines had been administered on each occasion. Details of the strengths and dosages of some medicines were not recorded. We also found gaps in the medicine records where some dates had not been signed for the administration of medicines. It was therefore not always possible to confirm if people had been given their medicines, or what medicines had been given. For two people, prescribed medication was given at an incorrect dose on a number of occasions. For another person who was prescribed creams and ointments which were applied by care workers, there were no accurate records kept of which creams were applied. This meant that it was not always possible to tell whether creams were being used correctly. The records showed that care workers were not following the service's policy on the safe handling of people's medicines.

The area manager told us that staff carried out spot check audits on the documentation returned to the office at the end of each month. We saw the audit for one person whose medication administration record (MAR) did not list the times that the individual medicines were administered. However this was not picked up and the audit summary stated 'no issues'. We also saw and were told that there was no system in place to confirm that the medicines listed on the MAR accurately matched the medicines administered by care workers.

We found that people using the service did not receive their medication as prescribed.

This was a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

People told us they felt safe when their care workers were in their homes. One person said, "I trust them." We saw the service had an appropriate policy in place for protecting people from abuse. This included the importance of working with the local authority safeguarding team or police investigation officers. A clear referral process was in place, with a useful flowchart for staff to follow, if they identified anything that was potentially harmful to people. It also included the phone number of the social services emergency 'out of hours' team. Clear records were kept of safeguarding incidents. These included details of any internal investigations carried out at the request of the relevant authorities.

The provider had a policy for preventing the risks of financial abuse. This included an assessment of the potential risk of financial abuse; a policy that prevented staff from accepting gifts from people using the service; and the staff handbook gave care workers a clear list of 'do's and don'ts' with regard to involvement in any financial transactions on behalf of people.

Staff were regularly reminded of the importance of reporting any poor or potentially abusive practice they might observe in the course of their duties. The provider had a 'whistle-blowing' phone line and an email contact for senior managers in the company, and this was given in the staff handbook and on all staff pay slips. The manager told us there had been no whistle blowing incidents in the past twelve months.

As part of the assessment of a person's needs, any risks in areas such as moving and handling, medicines, nutrition, falls and skin integrity were assessed and identified. The service informed the person's GP of any health risks identified. Risks in the person's home environment were also assessed. Staff were instructed to take appropriate actions to minimise risks by, for example, checking the stability of mobility aids before use. All accidents and other significant incidents were logged.

People told us their regular care workers were generally reliable and stayed for the agreed length of time. However, five of the people we spoke with by phone said they were

Requires improvement

Is the service safe?

unhappy with the timekeeping of care workers at weekends. A typical comment was, “The only real problem is at weekends when they get a bit late, they push so many visits in.” Six people said they did not always know which care worker would be coming to give their care, and said they were not informed of changes of worker. Comments included, “My worry is I am getting someone new next week and I don't know who it is”; “It can be a bit awkward when my regular carers are away”; and, “I don’t always know who is coming, but they are all okay.” No one we spoke with told us their calls were ever missed.

We noted there was a relatively high turn-over of care workers. The manager confirmed approximately 20% of the 103 care workers had left in the past year, many going to work in care homes. In an effort to retain care workers, the provider gave each worker alternate weekends off duty. We informed the manager of the many comments we had received from people using the service about poor timekeeping and not knowing who their carer would be at weekends. The manager said they were aware of these problems and told us of steps they had taken to increase recruitment. These included advertising for weekend-only contracts, attending job fairs, using social media as a recruiting agent, and launching a ‘We want you back’ campaign to re-employ former employees.

Records of staff recruitment showed that a robust system was in place to ensure only suitable applicants were employed. Appropriate checks were carried out regarding the applicant’s identity, employment history, health, and any previous convictions. References were taken up from previous employers, and the applicant underwent an interview that sought to establish their motivation, caring experience and ability, honesty and respect for vulnerable people.

The service had a policy and procedure relating to the care and safety of staff, with detailed guidance for staff contained within the staff handbook. In addition, staff underwent health and safety training, including safe lone working, in the staff induction programme.

Requires improvement

Is the service effective?

Our findings

People were happy with the skills and experience of their regular care workers. Comments included, “They know what they are doing, and they seem to be well trained”; “They are skilled”; and, “They know their job and they are well trained and very reliable.”

In the most recent (2015) provider’s survey of people’s views, 67% said their care workers always had the skills required to meet their assessed needs (27% said ‘mostly’).

We found all staff received a comprehensive four day induction training programme and were furnished with a training portfolio and staff handbook. These contained key policies and procedures across a wide range of areas including maintaining professional boundaries, confidentiality and whistleblowing.

Following their initial induction, new staff entered into a mentoring process called the ‘On Boarding’ process. All new starters were issued with a coaching passport booklet and were accompanied by an experienced carer on their visits. The new staff member’s performance was assessed across a range of topics including supporting the person in eating and drinking, mobility, washing and dressing, continence issues and help with medicines. They were signed off by the mentor when judged to be competent.

We examined the staff training log book and attendance sheet records and found numerous topics available to staff with good attendance for a number of courses. The training system was maintained centrally through the company IT system. Office staff were notified when staff members required training updates in the various statutory and mandatory topics and the training was then scheduled in the staff rotas by the care co-ordinators. Once training was completed, staff files were updated on the electronic staff system.

We found evidence that a robust system of staff supervision was in place. We found the records we examined were completed appropriately with reference made to staff performance and plans made for personal and professional development. Each member of staff received a supervision session every three months, with one being an annual appraisal. Supervisors used a grading score guidance matrix to help judge care workers performance across a wide range of areas such as interaction with people using the service, managing workload, and adherence to company policy. Field care supervisors conducted spot checks of staff practice in people’s homes. These checks covered areas including care practice, communication, staff presentation and professionalism in the customer’s home. We found evidence of appropriately completed documentation in the staff files regarding these checks.

People told us their care workers were careful to get their consent before carrying out any tasks, particularly regarding support with personal care. One person told us, “”They always ask me. And they know that ‘no’ means no.” Another person said, “My regular carers always ask first.” One person’s care plan stated, “Carer to assist X with showering if he gives consent.” We saw a form was signed giving consent to care as described in the person’s care plan, for sharing personal information with other professionals and for the administration of medicines. However, we found no evidence that the person’s ability to give informed consent had been assessed by the service. We saw examples of social worker assessments that clearly indicated where the person was deemed to lack the capacity to give informed consent, but where no ‘best interest’ decision making process had been undertaken. We saw examples of other people (for example, a ‘family friend’) having signed the person’s consent to care form, without having the legal authority to do so. We noted the assessment documentation used for the large majority of people did not address the question of mental capacity.

This meant the service was not acting in accordance with the Mental Capacity Act 2005 (MCA), which protects the rights of people who may lack mental capacity to make some decisions around their care and welfare.

This was a breach of Regulation 11 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

The manager told us new assessment documentation had recently been introduced which did specifically address the issue of mental capacity, and showed us examples. These showed the rights of the person under the MCA were understood and respected, with an appropriate process for assessing capacity and reaching ‘best interest’ decisions. The manager said all people receiving a service were being re-assessed using the new documentation at their annual review.

The service had a policy regarding the use of restraint, which allowed for the use of physical intervention only in

Is the service effective?

extreme circumstances, to protect the safety of the person or others around them. The training officer told us a training package was in place and staff would be given the appropriate training before any care package where challenging behaviours were present would be accepted. This was aimed at recognising the triggers that might cause such behaviours and using pro-active techniques to avoid the need for physical intervention.

People's food and drinks preferences were noted at their assessment, and any religious, cultural or health needs related to diet were recorded and included in the person's care plan. A new 'personalised individual eating and drinking needs assessment' had recently been introduced. People said they got the appropriate support with their drinks and meals. One person told us, "They make me my meals and leave me a drink."

The training officer told us all staff had been trained to use the 'early warning system', whereby care workers were obliged to report even the smallest change in a person's health or demeanour. This aimed to catch any significant physical and emotional health issues at the earliest possible stage, so that appropriate steps could be taken to stop conditions getting worse. Care workers we asked said they were always careful to look for any changes in a person's health and reported any concerns immediately to the office. For example, to report a small skin blemish, in case it developed into a pressure ulcer. People we spoke with confirmed this. One person said, "They picked up (a health issue) recently, and now it's sorted." Another person commented, "They rang the GP for me just the other day." A care worker told us how they had recently observed changes to a person's demeanour when prescribed a new medicine. They had reported this to the office who contacted the person's GP to review the medicine.

Training records showed staff were given annual refresher training in the use of mobility aids and other equipment used with people. Staff told us they were instructed to inform the office if they found unfamiliar aids or equipment in place, and not to use it until trained. They were also expected to report any new equipment they felt the person might need, and a risk assessment would then be carried out.

Good

Is the service caring?

Our findings

People told us they felt their care workers were very caring. One person told us, “They are very caring. They love me. They take great care of me.” A second person commented, “I love my carer to bits. She comes once a week and does everything I want: no problems, no problems at all.” A third person said, “The girls are so kind and patient. They put up with an awful lot.” Other comments made included, “They are definitely caring, and very sociable”; “I couldn't say a word against them, they are so nice”; and, “My carer is marvellous, I won't have any one but her.”

We noted numerous positive comments in the service’s compliments file. Examples included, “I absolutely love my carers; each and every one of them bring me happiness”; and, “Very happy with all my carers, they are all lovely.”

The training officer told us they incorporated core care skills and the importance of maintaining privacy and dignity, into every element of training they provided. This included extensive use of role play, whereby a care worker might be blindfolded whilst being transferred on a hoist, or be fed by another worker, so they could appreciate the potential indignity of the process. The trainer told us they fed back to the manager if a worker appeared to lack care skills or empathy, so that further supervision or shadowing could be provided, or a decision made regarding their suitability to give care appropriately.

People told us they had developed very good relationships with their regular care workers. They told us their workers were kind and considerate, hard-working, flexible and attentive. For example,

People told us their regular workers also did little ‘extras’ for them, such as putting the washing out or making the bed, even when this was not in the care plan. One person said, “They are very good. They always ask if I want anything else before they go.”

All staff had been trained in the importance of equality and inclusion. A care worker told us, “We are taught everyone is different, and to recognise and challenge any discriminatory practices or personal biases. We are aware of the legislation.” At assessment, the person’s religion or other belief system was recorded, along with their first language and fluency in English. People’s care plans included appropriate information about diet (for example, “Halal meat, only”) and practices (such as, “Prays five times a day.”)

People were asked for their views about their service. Postal surveys were sent out eight weeks after a care package was started, and then annually thereafter. We found the results of these different surveys were combined, and covered the last two years, so were not able to make a judgement of people’s current satisfaction with the service. People confirmed that senior staff came to see them shortly after their service started, to check they were happy with their workers and the care being delivered.

When a person started to receive a service, they were given a ‘welcome’ pack. This gave them information about the range of personal and practical care services available to them; their rights; contact numbers; assessment and care planning processes; safeguarding; confidential record-keeping; and how to ask for changes to their service. We noted, however, it did not specifically refer to the service’s complaints procedure. The manager told us this was given separately.

The service had recently introduced a ‘personalised individual emotional well-being, social inclusion and indoor activities’ assessment document. This recorded areas such as family contact, social isolation, feelings of vulnerability, anxieties, hobbies and interests, and methods of enhancing the person’s independence. Information from this assessment was being incorporated into the care plans of people newly in receipt of a service, and the manager said this would be extended to all people using the service at their annual review.

Although we saw a poster on the office notice board regarding the availability of local advocacy services, the service lacked a policy on the use of advocates, and there was no reference to advocacy in the service user guide.

People we spoke with complimented their care workers for paying attention to the need to protect their privacy and dignity. One person said, “They are very good about such things.” A second person commented, “They definitely look after my privacy and dignity.” Staff told us they were instructed about the importance of maintaining the confidentiality of people’s personal information during

Good

Is the service caring?

their induction. This information was also contained in the staff handbook. No-one we spoke with had any concerns about breaches of confidentiality. One person told us, "My carers never talk to me about other people they care for."

People told us their care workers encouraged and supported them to be as independent as possible. Comments included, "They help me do as much as I can"; "With help, I can shower myself, now"; and, "They really help me do what I can for myself." We noted the newly introduced care plan documentation had a clearer focus on aiding people's independence.

The manager told us the service did not undertake 'end of life' care packages. However, a section of the new assessment documentation was dedicated to the person's end of life wishes. This included recording any advanced decisions the person had made about their future care.

We recommend that the service seek advice and guidance from a reputable source, about supporting people to express their views and involving them in decisions about their care, treatment and support.

Requires improvement

Is the service responsive?

Our findings

People told us their care workers were responsive to their needs and their wishes about how their care should be given. Typical comments included, "They do things the way I want" and, "They listen to me". A relative told us, "They do everything for my relative very nicely. I am very happy with the service."

In the most recent provider's survey of people's views (2015), 67% said their care workers always met their assessed needs, and 27% said their needs were mostly met.

We found the methodology used for the large majority of people using the service did not include a thorough assessment by the service of their needs. It relied on information provided by the person's social worker. However, not all this information was found to have been incorporated into people's care plans. Significant issues not recorded in care plans included a significant mental health issue, a preference not to be showered by a female worker, and instructions about catheter care. The lack of full assessment had also resulted in people's care plans being largely 'task lists' that did not include the person's wishes, preferences or abilities. Although there was a section in the care plan methodology entitled "What is important to me as a person" this was frequently not used for this purpose, but as a statement of the basic care tasks. For example, "Carer to assist to shower, wash hard to reach places, assist to dry and dress, and encourage to change pads."

People we spoke with told us their regular care workers were responsive to their needs and requirements. However, the lack of detailed care planning meant that people experienced problems when their regular workers were not available and workers unfamiliar with their needs were allocated. People's comments included, "It was okay, but the good carers left. It's not so bad during the week but I dread the weekends" and, "I just cancel if I can't get my regular carer."

We noted the service was in the process of moving to a new assessment and care planning methodology. This was a much improved system that gave proper weight to people's wishes and abilities, and examples seen showed more detailed and appropriately person-centred care planning. However, this methodology was being applied to new people starting to receive a service, and there were no clear plans for upgrading existing people's care plans within an acceptable period. The manager told us, with existing resources, it was possible to re-assess a maximum of two people per working day. This meant people had not had a proper assessment of their needs, and their care plans did not reflect people's preferences for how their care was to be given.

This was a breach of Regulation 9 of the Health and Social Care Act (Regulated Activities) Regulations 2014.

We saw evidence of people's needs being reviewed annually in conjunction with their social worker, representatives and care workers. People told us they felt they could ask for changes in their care plan at their review, and anytime between reviews. One person commented, "Yes, I think I could ask for changes. I know I can ask for a male carer, if I wanted to." Another person told us, "I get my care plan reviewed from the office, and I am very vocal, so I can get things done." A third person told us, "My carers listen to everything I say."

Only a small number of care packages included a specific social element (for example, taking a person out for a walk or to go shopping). The manager told us, however, that staff were expected to be alert to evidence the person was becoming withdrawn or isolated (particularly following a bereavement) and to report this to the office. We noted the newly introduced assessment methodology specifically asked people if they felt isolated. The manager also told us of initiatives being introduced to involve people socially. These included an open day at the office to which people were invited, and a Christmas social event.

We saw the new care plan format being introduced appropriately reflected issues of personal choice and individuality. Examples seen included, "X usually likes scrambled eggs and toast and drinks coffee with one sugar and coffee whitener" and, "Offer Y choices, and encourage to eat what they want."

We found detailed information regarding complaints clearly written in the staff handbook and in company policy and procedures on the company intranet. The office staff were aware of the policy and procedures and explained that when complaints and incidents were reported they were logged onto the IT system. They were then forwarded to the relevant customer service staff at head office for investigation.

Requires improvement

Is the service responsive?

We examined two complaints in detail and found the policy had been followed appropriately, with evidence of the timescales for logging, investigation and resolution being met. We saw evidence of appropriately detailed investigation and that the service took responsibility for any mistakes or omissions, with suitable apologies given. Office staff said they adopted a personalised approach to complaint resolution and asked the complainant how they would like to receive the outcome, for example, by letter, email, verbally, by telephone or in person. We noted that this process did not, therefore, always result in a formal letter to the complainant detailing the complaint and outcomes.

People told us they knew how to complain, and some had done so. One person told us, "I have complained before. It was sorted properly and the company took responsibility." A second person said, "I've not needed to complain, but I would ring the office if I needed to." We noted, in the provider's 2015 survey of people's views, that 76% of respondents said the service 'always' or 'mostly' dealt with their problems effectively.

The service had received a number of compliments from people and relatives which were logged in a file and displayed on the office staff notice board.

Good

Is the service well-led?

Our findings

The service did not have a registered manager. The previous registered manager had left the company in April 2015. A new manager was appointed in May 2015. This person had applied to be registered with the Care Quality Commission, and their application was being processed.

People told us they were generally satisfied with how the service was managed. Comments included, "The office has improved recently"; "Allied is very good. It's one of the best around here"; and, "No problems at all." We asked those people who we visited in their homes how they felt the service could be improved. No-one suggested areas for improvement. Typical comments were, "I can't think of anything to be improved", and, "Not really, I'm quite happy with the service." We noted, in the service's compliments file, comments such as, "The company provides an excellent service" and, "Allied is a brilliant company. I am happy with the service received."

We noted, in the most recent (2015) provider's survey of people's views regarding the service, 88% rated their service as either good, very good or excellent, and that 82% would recommend the service to friends and family.

We found a clear management structure in place in the service, with good support from the provider's regional manager and head office. The manager explained their management style as being one of leading by example, and giving the structure and clarity of expectation necessary to build a team ethic and enable staff to carry out their roles effectively. They stressed the importance of listening carefully to the views both of the people who used the service and the staff providing their care.

We found evidence of regular staff meetings taking place at the office with a formal agenda and the company newsletter tabled for information and discussion. This was informative, positive in tone and clear in its messages to staff. Changes to roles, responsibilities and systems were spelled out clearly. Suggestions for improvements were regularly requested from staff. Care workers were thanked for their hard work and commitment. We noted, in one newsletter, the manager reminded staff, "You are not 'JUST' a carer. What you all do in your everyday role is so special, and the difference you make to the lives you touch is paramount. Thank you."

We found evidence of quality assurance and audit activity taking place within the service. This was carried out by the audit team from the provider's head office. We noted the audit tool contained twenty-seven measures which broadly corresponded to the requirements of the current legislation. No formal action plan had been produced regarding the findings of the most recent surveys. However, the manager was able to demonstrate steps had been taken to address the main areas of concern from people using the service, which were late calls and poor communication regarding changes to care workers. The manager had introduced logs to monitor late and cancelled calls, which recorded the numbers and reasons, and stated the actions taken to inform the person concerned. These logs were checked by the manager daily. An office duty system had been introduced to clarify which member of staff was responsible for contacting people. Protected time had been given for such communication, and for carrying out routine audits of issues such as medicine administration records. Checks were carried out of the quality, clarity and regularity of entries in the 'visit report book', kept in each person's house.

The system had a 'root cause analysis and learning' section for the service and provider to consider how the recurrence of complaints and incidents could be prevented in the future. However, it was unclear how this happened in practice as we were not shown clear evidence of how this learning was passed on to all staff. We also noted the service's quality systems had failed to recognise the problems noted with the safe management of people's medicines.

Customer satisfaction surveys were conducted by the company nationally. The results of these were accompanied by an analysis of the service's performance against others in the company. The regional Care Delivery Director told us the provider would soon be implementing a monthly customer care satisfaction survey to complement and add value to the annual survey conducted by the company. We saw people's annual reviews included a quality review form. People told us care co-ordinators visited them in their homes occasionally to review care documentation and ask their views on their service. One person told us, "I have no problems at all. Someone is due out from the office to check the paperwork soon."

Good

Is the service well-led?

We found that the service promoted a positive culture of care for people using the service in its newsletters and in the staff handbook which stipulated the expected behaviour of its staff.

We found a culture of openness and accountability within the service. Staff at all levels were open, helpful and supportive of the inspection process, and honest in their communication. We found a commitment to improving the service. The manager and staff were keen to learn, share good practice and made constructive suggestions for developing the service.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **Regulation 11 HSCA 2008 (Regulated Activities) Regulations 2014 Consent to care.** **The provider had not ensured people's care and treatment was given with the consent of the relevant person.** **Regulation 11 (1) (3).**

Regulated activity	Regulation
Personal care	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014 Safe care and treatment.** **The provider had not ensured the proper and safe management of medicines.** **Regulation 12 (2) (g).**

Regulated activity	Regulation
Personal care	Regulation 9 HSCA (RA) Regulations 2014 Person-centred care **Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2014 Person centred care.**

This section is primarily information for the provider

Action we have told the provider to take

The provider had not ensured person-centred care, in that an assessment of the needs and preferences for care of the person had not been carried out.

Regulation 9 (3) (a) (b)