Redspot Homecare (Contracts) Limited

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

Summary of findings

Overall summary

We inspected Redspot Homecare (Contracts) on 27, 30, and 31 January 2017. This was an announced inspection. We informed the provider 48 hours in advance of our visit that we would be inspecting. This was to ensure there was somebody at the location to facilitate our inspection. The service was providing support with personal care to 265 adults living in their own homes at the time of our inspection. This was the first inspection of the service since it was registered with the Care Quality Commission.

The service had an acting manager who had been in place since November 2016. They were about to start the process of applying to become the registered manager of the service. 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.

There were some arrangements to manage medicines safely and appropriately. Records showed care workers had received medicines training and medicines policies and procedures were in place. However, we found the service was not completing Medication Administration Records (MARs) when administering medicines to people effectively. Medicine risk assessments were being completed for people however they did not state the reason for taking medicines and any risks and side effects. People were therefore at risk of not receiving their medicines safely.

There was a sufficient number of staff to provide people with safe support and care. However, some people and their relatives told us care workers did not always arrive on time. Most of the people and their relatives we spoke with told us the provider was not notifying them of care workers running late and if a different care worker was covering a particular shift.

People were confident on how to make a complaint. However, the provider could not demonstrate they had an effective system in place for handling of their complaints.

The provider had failed to submit statutory notifications relating to significant incidents that had occurred. A statutory notification is a notice informing CQC of significant events and is required by law.

Systems were in place to help ensure people were safe. Staff had undertaken training about safeguarding adults and had a good understanding of their responsibilities with regard to this. Risk assessments were in place which provided information about how to support people in a safe manner. Staff understood their responsibilities under the Mental Capacity Act 2005. Referrals were made to health and social care professionals when needed.

Staff received regular training and were knowledgeable about their roles and responsibilities. They had the skills, knowledge and experience required to support people with their care and support needs.

Care plans were in place detailing how people wished to be supported and people and their relatives were involved in making decisions about their care. People's cultural and religious needs were respected when planning and delivering care. Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Staff told us they felt supported by the manager and the senior management team. Staff, people who used the service and relatives felt able to speak with the senior management team. The service had quality assurance systems in place. The service carried out audits of the service provision to ensure people's views were gathered.

We found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We also one breach of the Care Quality Commission (Registration) Regulations. You can see what action we asked the provider to take at the back of the full version of this 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

The service was not always safe. The administration and prompting of medicines to show people had received their prescribed medicines was not always recorded clearly. Medicine risk assessments were not robust.

People and their relatives told us care workers did not always arrive on time.

Risk assessments were in place to help ensure people were supported in a safe manner.

The service carried out safe recruitment practices.

Is the service effective?

Good

The service was effective. Staff undertook a comprehensive induction programme on commencing work at the service and then had access to on-going training and supervision.

The service worked within the Mental Capacity Act 2005 and people were able to make choices about their daily lives.

Staff were aware of people's dietary preferences. Staff had a good understanding about the current medical and health conditions of the people they supported.

Is the service caring?

Good

The service was caring. People who used the service and their relatives told us that staff treated them with dignity and respect.

People and their relatives were involved in making decisions about their care and the support they received.

People's cultural and religious needs were respected when planning and delivering care. Staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service.

Is the service responsive?

Requires Improvement

The service was not always responsive. People were confident on how to make a complaint. However, the provider could not demonstrate they had an effective system in place for handling of their complaints.

People did not always receive person-centred care. Most of the people we spoke with told us they were not notified if a different care worker was covering a shift or running late.

People's needs were assessed and care was planned in line with the needs of individuals. People and their relatives were involved in planning their own care.

People's needs were subject to review and the service was able to respond to people's changing needs.

Is the service well-led?

Requires Improvement

The service was not always well-led. The provider had failed to submit statutory notifications relating to significant incidents that had occurred.

Various quality assurance and monitoring systems were in place.

The service did not have a registered manager in place. There was an acting manager that ran the service. Staff felt the manager and the senior management team was open and supportive.

Redspot Homecare (Contracts) 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.

This inspection took place on 27, 30, and 31 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

The inspection team consisted of four inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. This expert had experience of caring for someone using a domiciliary care service.

Before the inspection we checked the information we held about the service. This included any notifications and safeguarding alerts. We also contacted the local borough contracts and commissioning teams that had placements at the service and the local borough safeguarding teams.

During the inspection we spoke with 21 people who used the service and nine relatives. We spoke with ten members of staff including the provider, the acting manager, the compliance manager, the care manager, two care co-ordinators, two supervisors and 19 care workers. We viewed 12 staff files including recruitment records, supervisions and appraisals. We viewed the care files of 30 people who used the service including support plans, risk assessments, medicines records, and records of care delivered. Various records and policies including the safeguarding policy, incidents, complaints, quality assurance, recruitment policy, training records, staff meeting minutes and feedback forms were viewed.

Requires Improvement

Is the service safe?

Our findings

People were at risk of not receiving their medicines safely. Medicines administration record (MAR) charts were not always clear when medicine should be given, what dose and any special information, such as giving the medicines with food. The provider's policy on the administration of medicines was not being followed. The provider's policy on medicine recording stated, "The medication administration record for an individual service user will include the name of the service user, date of birth, weight, name of the drug, the dose, and time be given, and any special requirements." MAR charts we looked at did not include what medicines had been taken and what dosage. Records only showed the care worker's signature, date and what time the medicines were given. This meant people were at risk of not receiving their medicines correctly.

The provider's policy on assessing risks for medicine administration was not being followed. The provider's policy stated, "Pre-commencement assessments of medication taken by the service user should be made to include medication name, dose, time of taking, reason for taking and service user understanding their medication." Records showed people who were supported with medicines had a medicine risk assessment. The medicine risk assessment documented what medicines and dosage people were to be administered. However the risk assessment did not state the reason for taking and any risks and side effects associated with each medicine documented.

The lack of effective systems for the management and administration of medicines meant that people were being put at risk of not receiving their medicines correctly and safely. When we spoke to the manager they told us they had identified the MAR charts being used were not robust. Records confirmed an email was sent to the care team on 28 November 2016 highlighting this with a copy of the new MAR chart to be used. However at the time of the inspection the new MAR chart had not been put into place. After the inspection the manager told us and sent records confirming the new MAR chart was being implemented from 1 February 2017. The implementation of the new MAR chart also included the care team contacting the dispensing pharmacies for guidance on medicine recording, care staff to receive training on the new MAR charts and more frequent spot checks looking at medicine recording.

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

Staff we spoke with told us there were sufficient numbers available to cover shifts if someone was absent from work. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people using the service and we saw that the number of staff supporting a person could be increased if required. The manager told us the service recently introduced an electronic system that would manage and monitor visits to people's homes. The system required staff to check in when they arrived at people's homes, enabling management to track the timelessness of visits in real time. However the manager told us there had been issues with this system and in the meantime the office staff were monitoring the most vulnerable people until it was working effectively.

People who used the service and their relatives told us they felt the service was safe. One person said, "I'm quite safe. I have the same [staff members] so I know who is coming." Another person told us, "Yes I feel safe. They [staff members] tap on the window when they arrive." A relative told us, "We have no problems with safety. Same carers mostly."

Staff knew what to do if there were any safeguarding concerns. They understood what abuse was and what they needed to do if they suspected abuse had taken place. Staff told us they would report any witnessed or suspected abuse to the manager or senior staff members. One staff member told us, "If you think there is abuse we let the office know." Another staff member said, "We had training including safeguarding adults and children and refresher training. If I had a concern, I would report to the supervisor straight away. The manager is also informed." Records showed all staff had received up to date training in safeguarding vulnerable adults. Information about safeguarding was available in the employee handbook which was given to all new members of staff when they first joined the service. One staff member said about whistleblowing, "Whistleblowing is anonymous. Won't get into trouble. I feel confident."

The manager and senior staff were able to describe the actions they would take when reporting an incident which included reporting to the local authority safeguarding team and the Care Quality Commission (CQC).

People's needs were assessed and risks identified. The risk people faced in relation to falls was based on a points system whereby people scored a point for each element that was deemed to put them at greater risk. For example, they scored a point if they had any falls in the past year, if they were unsteady on their feet, if they had an underlying health condition such as arthritis, if they had decreased physical strength or if they used any kind of walking aid. One point was awarded to each element and if the person scored four or more they were deemed to be at moderate to extreme risk of falling. Where this was the case there was an expectation that a care plan be put in place to guide staff on how to provide support that was safe in a way that mitigated the risks faced by the person.

Most of the risk assessments about falls were of a good standard, providing personalised information about how to reduce the risk people faced. For example, the risk assessment for one person stated, "The toilet door should be left open because she does not like to walk to the toilet with the zimmer frame [which meant the person did not have to open the door which would have increased the risk of falling]." The risk assessment for another person stated, "[Person who used the service] will use the bed stick to sit himself up in the bed. Once he is in a sitting position he will then be able to stand. He will need the assistance of two carers to transfer from the bed into the standing position. The carers need to stand either side of him and support his back. [Person who used the service] will use his zimmer frame to support his balance once he is upright." The risk assessment for a third person stated, "[Person] is able to push herself into a standing posture from sitting with the encouragement of staff. Once you allow her time to gain her strength and orientation. Escort her to the toilet, closely monitoring her as she mobilises using the zimmer frame."

However, we found that for one person they did not have an adequate risk assessment in place. The risk assessment tool had been completed incorrectly, giving them a score of two which was low risk when it should have been a score of four which was moderate risk. There was no detailed information about how to support this person to reduce the risks of falls. We discussed this with the care manager who told us the risk assessment for this person was not of a satisfactory standard and that they would ensure it was reviewed. On day 2 of the inspection the manager showed us the risk assessment had been updated to a satisfactory standard.
Risk assessments were also in place in relation to medicines and the physical environment. The risk assessment of the physical environment included an assessment of risks associated with flooring and trip hazards and electrical appliances.

The service had a robust staff recruitment system. All staff had references and criminal record checks were carried out. This process assured the provider that employees were of good character and had the qualifications, skills and experience to support people using the service.

The service had an infection control policy which included guidance on the management of infectious diseases. Staff were aware of infection control measures and said they had access to gloves, aprons and other protective clothing. During the inspection we saw staff coming into the office to collect protective clothing. One staff member told us, "The company provide protective clothing and gloves all the time."

Good

Is the service effective?

Our findings

People who used the service and their relatives told us they were supported by staff who had the skills to meet their needs. One person told us, "They [staff] are friendly and seem to be well trained." Another person said, "The ones I have are quite competent." A relative said, "[Staff member] seems very knowledgeable. Think [staff member] has had dementia training."

New staff were supported with a five day induction programme. The induction covered topics including understanding your role, duty of care, equality and diversity, privacy and dignity, medicines, nutrition, safeguarding adults, basic life support and health and safety. The induction also included training on specific health conditions such mental health, dementia and learning disabilities. Newly employed staff were also supported to do the Care Certificate. The Care Certificate is a training programme for all staff to complete when they commence working in social care to help them develop their competence in this area of work. Staff told us that new staff shadowed more experienced staff members before they were expected to work independently. One staff member told us, "We do training for a week before starting and shadowing was for a week." Another staff member said, "We had induction. We did shadowing for two weeks." A third staff member told us. "I had induction. Five days training course and shadowing before I worked alone. I felt confident when I started and now more so."

Staff we spoke with told us they were well supported by the service. They said they received training that equipped them to carry out their work effectively. Staff training records showed staff had completed a range of training sessions. Training completed included food hygiene, medicines fire safety, infection control, safeguarding adults, diversity and equality, health and safety, conflict resolution, moving and handling, basic life support and Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed staff did more specialised training when needed, for example, challenging behaviour and catheter care. One staff member said about the training, "Very good. Refreshers every six months to one year. NVQ we don't pay for this." The NVQ is a work based qualification which recognises the skills and knowledge a person needs to do a job. The candidate needs to demonstrate and prove their competency in their chosen role or career path. We are reminded when training is due." Another staff member told us, "If I want any particular training, like end of life, I can have it. I've had dementia training." A third staff member told us, "They teach you everything and keep you up to date. I really like that. They give you a choice of training."

The provider had a supervision policy that stated, "Every employee will be invited to a supervision/monitoring session with their manager or supervisor at least four times a year." Records showed most staff were receiving formal supervision twice a year and formal observations more regular. We spoke to the manager about the frequency of formal supervisions being every six months. She told us the service would be implementing formal supervisions four times a year immediately. Staff received regular formal supervision and we saw records to confirm this. One staff member said about supervision, "Every six months plus spot checks." Another staff member said, "Supervision they come in and see what is going on. Just did supervision late last year." A third staff member said, "I have supervision next month. I started in November and this will be my first but we always meet and communicate." Annual appraisals with staff to discuss and provide feedback on their performance and set goals for the forthcoming year were carried out.

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. Records showed that mental capacity assessments of people in line with the Mental Capacity Act 2005 had been completed. Where people lacked capacity we saw that family members and the commissioning local authority were involved in making decisions on their behalf. Care plans indicated that people were able to make decisions about their care. For example, the care plan for one person stated. "[Person who used the service] will be able to direct the carer and advise them on the level of support she will require when having a shower or wash." People had signed consent forms to agree to the service carrying out various tasks such as photographing any pressure wounds the person had and staff reading confidential information about them. Consent was also sought where care workers supported people using the service to take prescribed medication. This showed us that people's ability to make decisions and consent to the care and support provided was considered.

The manager and staff had an understanding of the MCA and how the act should be applied to people living in their own homes. Staff explained how they supported people to make choices about their daily lives. Staff also told us they spoke with people who used the service and family members to get an understanding of people they supported and their likes and dislikes. One person told us, "They [staff] will ask me if I am ready to go to bed or before they wash me." Another person said, "They [staff] will ask what I want doing." One relative told us, "Always ask if there is anything more they can do." A staff member said, "You have to ask permission." Another staff member told us, "You always have to ask."

Where the service supported people with food preparation care plans included information about people's food preferences. For example, the care plan for one person stated, "[Person] prefers toast with margarine and a cup of coffee with milk and two sugars [for breakfast]." The care plan for another person stated, "[Person] always has a sandwich for lunch and her favourite filling is ham. This can vary so carers must always involve her when preparing the sandwich." Staff member told us, "I prepare food for people. It's personalised. They tell me what they want. [Person who used the service] who is bed bound and not very vocal has in her care plan she likes a small cup of milk and two slices of toast with lots of butter. So I make that for her." One person told us, "They [staff] ask me what I would like today and get it ready for me." Another person said, "They [staff] will help me with preparation. Get things out of the fridge for me and supervise." A relative said, "[Relative] has ready meals. They [staff] make suggestions and [relative] chooses."

Records showed that the service made appropriate referrals to other agencies where there were concerns that a person's needs were not been adequately met. For example, one person who self-administered their medicines told their care staff they had not been taking them recently and this was reported to the person's social worker. We saw for another person a referral had been made to social services because the person's mobility had declined after a stay in hospital. One relative said, "Yes they [staff] help with all his appointments." Another person told us, "I am prone to infection. Carer has had to call 111 and get doctor in." Care plans included details of people's GP, their prescribed medicines and any medical conditions they had. This meant that people were supported to have access to healthcare services and receive on-going healthcare support with the help of care workers when necessary.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us staff treated them with dignity and acted in a caring manner. One person told us, "[Care worker] is wonderful. I love her." Another person said, "[Care workers] are very friendly and do what needs doing." A third person told us, "They [care workers] are very warm people." A fourth person said, "I'm very happy. I can't fault them. They are a great help. They treat me very well." A relative told us, "They [staff] all have their own way of showing how they care." Another relative said, "They [staff] are most positive. Always encouraging. They hold [relative's] hand." However one person said, "One [care worker] told me if it wasn't for the money she wouldn't do the job."

Staff told us they enjoyed working with the people they provided care for. They said that they shadowed care workers to help build a relationship with people who used the service and to get to know them better. One staff member told us, "We are there for them." Another staff member said, "You feel needed and appreciated. It makes you feel good."

Staff told us how they made sure people's privacy and dignity was respected. They said they explained what they were doing and sought permission to carry out personal care tasks. One staff member told us "If I'm going to shower someone I'll ask them what they want done. It's their care. It's not about my needs." Another staff member said, "You should shut the door and curtain." One person told us, "I am quite independent and they [staff] help but don't intrude." Another person said, "They [staff] will knock before coming in." One relative said, "Everything is done behind closed doors."

People were encouraged to maintain their independence and undertake their own personal care where possible. Where appropriate staff prompted people to undertake certain tasks rather than doing them for them. Staff gave us examples of how they helped people to be independent. One staff member said, "If someone can do their own personal care then I let them." Care plans included information about supporting people to maintain their independence and enabling them to manage tasks for themselves where possible. For example, the care plan for one person stated, "Fill bowl with water and allow [person who used the service] to wash her face and hands. Then assist her with washing and dressing her top half. Once this is complete help her change in to a clean blouse, assist her to stand and wash underneath and dry." The care plan for another person stated, "[Person who used the service] can wash top half but requires assistance with the rest. Assist him to wash his back, bottom and feet and ensure everywhere is dried sufficiently."

People were involved in making choices about their care. One member of staff told us, "We have to ask them [people who used the service] about what they like." Another member of staff told us, "I show them clothes and ask what they want to wear until they are satisfied." One person told us, "They [staff] are very kind and caring. They do anything I ask of them." Another person said, "[Staff member] knows my likes and dislikes." The care plan included information about people's choices. For example one stated, "Ask [person who used the service] what she would like to wear." The care plan for another person stated, "Please prepare a small selection of snacks and cover with cling film. [Person] will tell you what she will like."

People's cultural and religious needs were respected when planning and delivering care. For example,

where possible, staff respected people's wishes when preparing culturally specific food. Records showed that people could request a care worker of the same gender. Another example, one person prayed at a specific time so the care times were changed to support the person. One staff member told us about supporting someone with specific cultural needs, "I respect that. We are all human beings." Another staff member said, "I have a [specific religion] client. She covers her head." A third staff member said, "Never refuse helping people of a different culture."

Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people could feel accepted and welcomed in the service. One staff member said, "We are all equal. If lesbian, gay or straight we must treat everyone the same." Another staff member told us, "I wouldn't treat them differently." A third person said, "If someone told me they're gay, it's business as usual. It's not different."

Requires Improvement

Is the service responsive?

Our findings

People expressed mixed views about care workers arriving on time. Twelve out of the 30 people we spoke with told us staff arriving late was an issue. One person told us, "Time keeping is an issue." Another person said, "They can be late sometimes. Evening times can be a problem." A third person told us, "Too many [people who used the service] and not enough [staff]." A fourth person said, "Can come at all sorts of times." However another person told us, "They [staff] are never really late." This meant that some people were not always seen at their allocated time and put them at risk if they had time specific needs.

Most of the people we spoke with told us they were not notified if a different care worker was covering a shift or running late. For example, if their usual care worker was absent from work. One person when asked if the provider will let them know if there is a change of care worker said, "No they didn't let me know." Another person told us, "Never call if they are late." A third person said, "They are rubbish. I'm not kept in the loop. Don't respond to simple messages." A fourth person told us, "I'm not informed when they are running late." A relative said, "There is no phone call to keep us informed." Another relative told us, "One of the carers has not turned up for the last two days. We haven't been notified. If it wasn't for the other carer we would have had problems." However one person said, "They text me if the girls are going to be late." This meant the service was not providing person-centred care by notifying people of staff absences and potentially leaving some people vulnerable and without timely care intervention.

The above issues were a breach of Regulation 9 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The provider had a complaints policy that stated complaints would be acknowledged within 24 hours and responded to with a full response by 28 days. This was not always the case in the complaints logs seen. On day two of the inspection we were shown the new electronic complaints log. This showed that in the last 12 months there had been 24 complaints. Out of these 22 were recorded as being resolved and closed and two were pending awaiting external feedback. Senior staff advised that further details about the complaints were available in the complaints folder. This folder however contained only three, not 24 complaints, two in the 12 months and one dated back to 2015. Apart from one, the full investigations in relation to these complaints had not been recorded. On day three of the inspection senior staff told us we were given the wrong information and it was actually 15 complaints recorded on the new electronic complaints log not 24. The care manager told us complaint information records were not always robust from January 2016 to July 2016 as the previous senior staff had not updated and maintained the records effectively. This meant whilst the provider had a complaints policy and procedure in place, the lack of records in relation to complaints investigations meant the provider could not demonstrate the effective handling of their complaints.

This was a breach of Regulation 16 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People and relatives we spoke with were confident on how to make a complaint. One person told us, "I would contact the office." Another person said, "I would contact [supervisor]." A third person told us, "I can

contact them. No, haven't had any complaints." A relative said, "If I had issues I would contact the office." Another relative told us, "I would contact the office. Nothing so far."

The care manager explained the referral and assessment process to us. They told us they initially received a referral from a local authority which they considered to, "See if we have the capacity to meet their needs." They told us they then phoned the person's family to check if there was any relevant information about the person that had not been provided by the local authority. However, they told us they did not record this information but passed it over to the care staff verbally. This meant there was a possibility that relevant information could get lost and not passed on to care staff.

The care manager told us that assessments of people's needs were not carried out prior to the provision of care. They said it was aimed that assessments were to be completed within the first three days of care provision and on the first day of care provision for the more complex cases. These were carried out by a supervisor who visited the person for the purpose of carrying out an assessment at the same time as one of the care staff visited to provide care. Assessments were completed on a standard pro-forma which included an assessment of needs in relation to medicines, falls, likes and dislikes and personal care needs. Records confirmed this.

The initial assessments were then used as the basis for the care plan which was written by the same supervisor who carried out the assessment. This supervisor was then allocated as the keyworker for the person and was their first point of contact if they had any concerns. The keyworker was also responsible for carrying out reviews of the care plan which helped to provide continuity of care. All care plans were checked and signed off by the care manager before being put into place. The care manager told us this was to make sure they contained all necessary information, they were person centred and to check if any referrals were needed to other health or social care agencies such as physiotherapists or dieticians. One person told us, "They [staff] did a full assessment at the beginning."

The care manager told us the supervisor visited people after their first week of receiving care to check things were going well and if anything needed to be changed. They told us care plans were subject to regular review, saying, "We review the care plans every three months" and records confirmed this. The care manager added that care plans were reviewed more frequently than three months if there was significant change in need and that if a person went in to hospital this would automatically trigger a review of their care plan. One person told us, "[Staff member] has done a reassessment. She explains everything well." A relative said, "We've had a full assessment and regular reviews with supervisor." This meant care plans were able to reflect people's needs as they changed over time.

At the time of our inspection the service was in the process of changing their care plans. They told us the new system of care plans was more person centred and that it was planned that by the beginning of October 2017 every person using the service would have the new style of care plan in place. They said at the time of inspection approximately 40% of people had the new style of care plan. They added that all people who had newly started to use the service since the end of November 2016 were automatically on the new style care plans and records confirmed this.

Care files included a 'cloud map' document. This consisted of a photograph of the person surrounded by images of clouds. In each cloud there was brief information about the person's likes and preferences which provided personalised information about the individual. For example, clouds included information about people's likes in relation to what time they got up in a morning, what the liked to read and watch on television, what they liked to wear, eat and drink.

Care plans also included a profile of the person which included personalised information about them which helped staff to get a good understanding of the person to help them build good relations with them. For example, in one care plan it stated, "[Person who used the service] lives alone in her own home, she has two pet cats that keep her company. She enjoys the company of others and especially enjoys having her grandchildren around. She was born in [country] and enjoys talking about it. She likes music and watching television. She especially enjoys reading and has a large collection of books."

Care records contained detailed guidance for staff about how to meet people's needs. There was a wide variety of guidelines regarding how people wished to receive care and support including health and wellness, comfort and mobility, medicines, psychological and emotional needs, cognition, communication and nutrition. Care plans included personalised information about how to support individuals with their personal care. For example, the care plan for one person stated, "As you enter call out to [person who used the service] that you have arrived. Go in to her bedroom and assist her to sit up. Give her time to get her breath and assist onto glide commode. Fill the cup with water and put toothpaste on her brush. She will brush her own teeth. Use the jug to spit into then rinse clean."

Requires Improvement

Is the service well-led?

Our findings

During the inspection visit we identified the provider had failed to submit statutory notifications relating to significant incidents that had occurred. For example, we identified two safeguarding concerns that we had not been notified about. A statutory notification is a notice informing CQC of significant events and is required by law.

This was a breach of Regulation 18 of the Care Quality Commission (Registration) Regulations 2009 Notification of other incidents.

Most people and their relatives told us they had regular contact with senior staff and the office staff. One person told us, "I think the service is very well managed." Another person said, "Saw management initially. I really couldn't do without them." A relative told us, "It is well managed."

The service did not have a registered manager at the time of our inspection. The service had employed an improvement and development manager whose duties included the acting manager responsibilities. The manager had been in the role since November 2016. After the inspection we were told the acting manager was in the process of applying for the registered manager role.

Senior staff spoke highly of the acting manager. They said they felt comfortable raising concerns with them and found them to be responsive in dealing with any concerns raised. One senior staff member told us, "When [previous registered manager] left we realised we were not following a lot procedures efficiently. [Provider] brought in [manager] to develop us and show us the way." The same senior staff member said, "When [manager] came on board she joined up the dots. I find her supportive and making you see the journey." Another senior staff member told us, "Paperwork has changed since the new management. It's a lot more detailed now." A third senior staff member said, "Things are more structured."

The care workers we spoke with felt supported by the manager and the office team. One staff member told us, "Management support me well." Another staff member said, "Manager is very helpful and supportive." A third staff member told us, "Very well supported in the office, co-ordinators, and managers."

People and their relatives were provided with a service user handbook. The information set out how the service planned to support people with care. For example, the service user guide stated, "Recognise the individual uniqueness of service users, staff and visitors, and treat them with dignity and respect." The service user guide also clearly stated the 24 hour contact number for the service, how to make a complaint, detailed the process of the initial referral, care and risk planning, care plan reviews and how the service monitors the quality of the service.

The office staff told us the service had regular staff meetings. Staff said that team meetings were helpful and that all staff had input into discussions about the service. Records confirmed that staff meetings took place regularly. Agenda items at staff meetings included risk assessments, supervisions, complaints, training, recruitment, spot checks, medicine charts and the Mental Capacity Act 2005 (MCA). The manager told us she

had started weekly management team meetings and records confirmed this. Topics included recruitment, induction, quality and compliance, spot checks, training and supervisions.

Records showed meetings with the care staff were held every six months. The last care staff meeting was 16 December 2016. The minutes included topics on the new electronic call monitoring system, the introduction of the acting manager, and supervision and appraisals. Care staff told us they had group meetings with their supervisors more regularly. One staff member told us, "We meet once monthly in a park and share ideas with my supervisor."

The service gathered the views of people who used the service and relatives through the use of an annual survey. One person told us, "I've had one survey by post. [Staff member] has been in too and asked how things are going." Another person said, "They [staff] have asked how things are and if I am OK with the service." A relative said, "The supervisor comes often. She monitors the [staff members] and checks all is well." The most recent survey was sent out September 2016. The survey covered topics on behaviours of care workers, information shared, respect and privacy, safety, professionalism, and care workers skills. The service analysed the surveys and had produced a report with the findings. The report did not state how many surveys had been returned however we counted 26 returned forms. The survey report was mostly positive. The report highlighted concerns found and then actions taken. For example, 12% of people felt they had not been given enough information about Redspot Homecare. We saw actions taken included reviewing the service user guide and sending out a copy to all the people they supported. Another example, a person stated on the returned survey form that changes had been made to the care plan however a copy of the new care plan was not in the person's home. We saw an action for the supervisor to visit the person's home and update the paperwork. Comments on the surveys included, "Daily support from [staff member] is excellent" and "Very kindly makes my bed and changes, washed my back, feet and legs. Very pleased with the care." The manager told us the next annual survey would be sent out April 2017.

The service also gathered the views of people who used the service with regular spot checks and telephoning call monitoring. People we spoke with and records confirmed this. One person told us, "They [office staff] have rung from time to time." One staff member said, "We have spot checks every three months, but you can get them anytime and they are all unannounced. If any improvements are needed about your care, they tell you in private. I find the spot checks very helpful, they keep you in check." Another staff member told us, "They [office staff] come and check everything." A senior staff member said, "During spot checks we look at whether carers are respectful. We look at the Medicines administration record (MAR) charts, and communication books."

The manager told us since starting the role in November 2016 the quality assurance systems had become more robust and records confirmed this. The service had a compliance team based at the location. The compliance manager told us the team took over the quality assurance for the service when the manager started. For example, regular audits were now taking place. Regular audits included looking at recruitment, care files, care plan reviews, medicines training, and supervision and appraisals. The compliance team had also started doing quarterly telephone surveys to people who used the service. The last audit was December 2016 and we saw records of this. The survey looked at attendance, meal preparation, timesheets, care worker's wearing protective clothing, records up to date in people's homes, and if happy with the service. The results showed that two out of 28 people were not happy with the service. The compliance manager and records showed that the compliance team would contact the care manager to follow up. For example, one relative had concerns that care workers could have a better understanding of dementia. We saw a letter to the relative acknowledging their concerns and advising staff had recently attended refresher training on dementia. We saw the manager and the compliance team had started to identify some issues we had identified during the inspection. For example, records were not robust for complaint handling and medicine

recording.

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 18 Registration Regulations 2009 Notifications of other incidents The provider had failed to notify of abuse or allegation of abuse in relation to service users. Regulation 18 (1) (e)

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person-centred care The provider was not providing person-centred care by notifying people of staff absences and potentially leaving some people vulnerable and without timely care intervention. Regulation 9 (1) (b) (c)

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Medicines were not administered and assessed appropriately which meant that people did not always receive their medication safely and as prescribed. Regulation 12 (1) (2) (a) (g)

Regulated activity	Regulation
Personal care	Regulation 16 HSCA RA Regulations 2014 Receiving and acting on complaints The provider had failed to ensure complaints were investigated and responded to appropriately. The provider has failed to maintain a record of all complaints, outcomes and actions taken in response to complaints.

Regulation 16 (1) (2)