

Immaculate Grace Care Ltd

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Inspection report

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Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Good 

Is the service effective?

Requires Improvement 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Good 

Summary of findings

Overall summary

Immaculate Grace Care Ltd is a domiciliary care agency registered to provide personal care to people living in their own home. At the time of this inspection visit they provided personal care to 30 people and employed approximately 28 care staff.

At the last comprehensive inspection in October 2015, we rated effective as requires improvement as we found care staff had not always received an induction at the start of their employment that prepared them for their role, or received the training required to effectively carry out the duties they were employed to perform. This was a breach of the regulations. We undertook a focused inspection in December 2016 to check the provider had made the required improvements and found they had met their legal requirements and were no longer in breach of the regulations and we rated the service as good.

Since our last inspection we have reviewed and refined our assessment framework, which was published in October 2017. For this inspection, we have inspected all key questions under the new framework, and also reviewed the previous key questions to make sure all areas were inspected to validate the ratings.

The office visit took place on 11 and 12 April 2018 and was announced. We told the provider we were coming so they could arrange to be there and arrange for staff to be available to talk with us about the service. The provider and registered manager were unavailable on the first day of inspection but were available on the second day.

Prior to our inspection visit we had received complaints from some relatives about the care and support provided to their family members. Their concerns were mainly about inconsistency of care staff and visit times, and staff not using a hoist safely. We referred the complaints to the local authority for investigation. People we contacted during our inspection reported similar concerns. We reviewed people's concerns during our inspection.

A requirement of the provider's registration is that they have a registered manager. There was a registered manager in post at the time of our inspection. 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 enough staff to provide the care and support people required. However, people had different experiences in the punctuality and continuity of care staff. Some people received care from staff they knew well and who arrived around the time expected. Others had experienced late calls and received care from unfamiliar staff, particularly at weekends. All the people we spoke with said care staff stayed long enough to provide the care they required.

People's right to make their own decisions about their care were supported by managers who understood

the principles of the Mental Capacity Act. Some staff had little understanding of the Act, however, they respected decisions people made about their care and gained consent before assisting people with care or support. Care plans did not include an assessment of people's capacity to make decisions or, where required, how people were supported to make decisions about their care and support.

People said they felt safe using the service and staff understood how to keep people safe from abuse. There were processes to minimise risks to people's safety. These included procedures to manage identified risks with people's care and for managing people's medicines safely. The suitability of staff was checked during recruitment procedures to make sure they were safe to work with people who used the service.

Staff received an induction when they started working for the service and completed training to support them in meeting people's needs effectively. Most people said staff had the right skills to provide the care they required, although some people said not all staff were able to use a hoist to move people competently. Staff were provided with protective clothing, such as disposable gloves and aprons to wear when providing personal care to reduce the risk of infection being passed from one person to another.

People told us they received care from staff that were friendly and caring, and who treated them with dignity and respect. All staff we spoke with knew the people they visited well, and spoke about people in a caring and considerate manner. When needed, arrangements were in place to support people to have enough to eat and drink and remain in good health.

People had an assessment completed at the start of their service to make sure staff could meet their care and support needs. Care plans provided information for staff about people's individual care needs and plans were regularly reviewed and updated when needs changed. Not all identified risks had plans completed for staff to follow.

People knew how to complain, and information about making a complaint was available for people.

Staff felt supported to do their work effectively and said the managers were approachable and available. There was an 'out of hours' on call system which ensured support and advice was always available for staff. Staff had regular supervision and observations of their practice to make sure they carried out their role safely.

Since the last inspection the provider had increased the management team. An assistant manager had been appointed and they had recently introduced the role of care supervisor to assist with staff observations and supervisions, and to carry out reviews of people's care. The management team worked well together and were clear about their roles and responsibilities.

The provider's quality monitoring system included asking people for their views about the quality of the service. This was through telephone conversations, visits to people to review their care and satisfaction questionnaires. The management team checked people received the care they needed by observing staff during visits to people and through feedback from people and staff.

There was a programme of other checks and audits which the provider used to monitor the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good 

The service was safe.

Staff understood their responsibility to keep people safe and to report any suspected abuse. People received support from staff who understood the risks identified with their care and knew how to support people safely. People felt safe with staff, and there were enough staff to provide the support people required. The provider checked the suitability of staff before they were able to work in people's homes. People who required support received their medicines as prescribed.

Is the service effective?

Requires Improvement 

The service was not consistently effective.

Care staff completed an induction and training to make sure they had the knowledge and skills to deliver effective care to people. Some people who used a hoist said some staff's moving and handling practice needed improving. The managers understood the principles of the Mental Capacity Act, but people's capacity to make decisions was not assessed or recorded in care plans. Care staff respected decisions people made about their care but some staff had very little understanding of the Act or how to put this into practice. Where required, staff made sure people had enough to eat and drink and referred people to healthcare professionals if needed.

Is the service caring?

Good 

The service was caring.

People said care staff were caring, kind and respectful and always ensured their privacy, dignity and independence was maintained.

Is the service responsive?

Requires Improvement 

The service was not consistently responsive.

Most people received a service that was based on their choices and preferences. However, some people did not always receive

their care at the times expected and by staff they knew. Not all identified risks had been transferred to care plans to ensure staff had all the information they needed to provide care safely and effectively. People knew how to complain if they needed to.

Is the service well-led?

Good ●

The service was well led

People said they were satisfied with the care they received from their regular care workers and were able to share their opinion about the service provided. Care staff received the support and supervision they needed to carry out their roles and felt confident to raise any concerns with the management team. The provider and registered manager were aware of peoples concerns in regard to late weekend calls and some staff practice and had implemented an action plan to improve the service people received.

Immaculate Grace Care Ltd

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.

Immaculate Grace Care Ltd. is a domiciliary care agency. It is registered to provide personal care to people living in their own homes.

This comprehensive inspection was carried out by one inspector 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. The expert by experience made telephone calls to people prior to the office visit.

The provider had completed a Provider Information Return (PIR) before this inspection. The PIR 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 information in the PIR during the inspection and found it was an accurate assessment of how the service operated.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the provider had sent us. A statutory notification is information about important events which the provider is required to send to us. Commissioners are people who contract care and support services paid for by the local authority.

Prior to the office visit we had received complaints from some relatives about the service their family member received. These included care staff arriving late for calls at weekends and dissatisfaction with the standard of care provided. We referred the complaints to the local authority for investigations and reviewed people's concerns during the inspection visit.

The office visit took place on 11 and 12 April 2018 and was announced. We told the provider we were coming so they could arrange to be there and arrange for care staff to be available to talk with us about the service.

We asked the provider for a list of people who used the service. This was so we could send surveys to people and contact people by phone to ask them their views of the service. Surveys were sent to 11 people who used the service and 11 relatives. We also sent surveys to 29 care staff. Surveys were returned from three people who used the service and five care staff.

We spoke with 20 people by telephone. This included five people who used the service, 14 relatives and an agency care worker. We used this information to help make a judgement about the service.

During our visits we spoke with the provider and registered manager, the assistant manager, two care supervisors, the office administrator and three care staff. We reviewed five people's care records to see how their care and support was planned and delivered. We looked at four staff recruitment files, staff training records, records of complaints, and records associated with the provider's quality monitoring systems.

Is the service safe?

Our findings

At this inspection, we found the same level of protection from abuse, harm and risks as at the previous inspection. The rating continues to be Good.

We asked people if they felt safe with the staff who visited them. People who completed surveys and who we spoke with told us they did. One person told us, "Yes I do, the carers are respectful to me and my home." Another said, "Yes I feel safe with regular care staff who visit in the week, we have a good laugh together and they know how to use the hoist." A relative said, "Yes [name] is safe because the carers are so respectful and very polite."

Staff understood their responsibilities to keep people safe and protect people from the risk of harm or abuse. Staff had completed safeguarding training and knew how to identify possible abuse and how to report it. For example, they told us this could include physical abuse, financial abuse, and neglect. The provider and registered manager understood their responsibility for reporting any safeguarding concerns to the local authority safeguarding team and to us.

Everyone we spoke with knew who to speak to if they had concerns about their safety. People said they would contact the staff in the office or had relatives who would do this for them. One person explained they had extended family living very close who were, "In and out of the house" so someone was always available if they had any concerns. A relative told us, "I would contact social services and if they didn't do anything I would talk to you, (CQC)."

Care staff were aware of their responsibility to report any concerns about other staff's practice and said they would report any concerns to the managers. Staff were confident appropriate action would be taken. Staff knew the provider had a whistleblowing policy that would support them to share any concerns they had.

The provider had an out of hour's on-call system to support staff when the office was closed. One staff member told us, "I have used the on call, it works well." This gave staff reassurance there was always someone available if they needed support.

The managers told us there was enough staff to allocate all the calls people required. All the staff we spoke with confirmed there were enough staff, and said they had weekly rotas that informed them of the people they would be visiting and the time they should arrive. We looked at the call schedules for three people whose care we reviewed and for three staff we spoke with. These showed calls were scheduled to people for the same time each day and allocated to a small team of care staff. Staff said calls to people usually remained the same on their rotas to ensure continuity of care.

The provider made recruitment checks on staff prior to employment, to ensure they were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about criminal backgrounds and

whether they are barred from working with people who use services.

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. For example, where people required help to move around, risk assessments detailed the equipment required and how they should be moved safely. Staff said they were confident using equipment to move people and made visual checks on the hoist and slings before using them to make sure they were in good condition. A supervisor told us they had a good relationship with district nurses and occupational therapists if they required advice or to request equipment for people.

We looked at how medicines were managed by the service. Most people we spoke with administered their own medicines, or their relatives helped them with this. Where people were supported by staff, they told us their medicines were administered as prescribed. One person told us, "No problem with medicines. They gave me some medicines that I take regularly, others I took myself when I needed them."

Staff told us they were confident giving medicines and knew what to do as they had received training to administer medicines safely. Staff we spoke with told us they checked medicines against a medicine administration record (MAR), then recorded in people's records that medicines had been given and signed to confirm this on the MAR. Records confirmed staff completed medication training but there was no evidence that staff had been assessed as competent to give medicines safely. The managers said that staff were observed giving medicines during their 'spot checks'. The registered manager confirmed a separate competency assessment would be implemented to make sure care staff were safe to give medicines.

MARs were checked by staff for any errors during visits to people and were checked by supervisors during spot checks on staff, to make sure they had been completed correctly. MARs were returned to the office monthly for auditing. Following the commissioner's visit in March 2018 the provider had improved the recording of medication. For example staff had been instructed to sign their initials on the MAR instead of recording A for administered and P for prompting, which follows recommended good practice guidance for recording medicines.

The provider had a system to record and monitor any accidents and incidents that occurred. Their PIR told us, "We monitor and review all accidents and incidents to identify any trends and potential corrective action, and review actions taken for effect." Incidents had been recorded, no trends had been identified.

Care staff were issued with identity badges and uniforms for use when attending people's homes so people could be reassured they were Immaculate Grace Care staff.

Staff were provided with personal protective equipment, such as aprons and gloves to enable them to promote positive infection control measures.

Is the service effective?

Our findings

At our last inspection we rated effective as good. At this inspection we found staff continued to have the experience and skills to provide effective care to people. However, procedures and staff knowledge in relation to the Mental Capacity Act needed improving. We have rated effective as requires improvement.

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 managers understood their responsibilities under the MCA. They told us all the people they supported were able to make daily decisions about their care, or had relatives who could make decisions in their best interests. Some people lacked capacity to make certain decisions, such as manage their finances, and where needed people had relatives with the authority to support them with this. We advised the provider and registered manager that where relatives or others have the authority to act on a person's behalf a copy of the authorisation should be retained in their records.

Managers and senior staff told us they assessed people's capacity to consent to their care service at the initial assessment visit. However, there was no assessment of capacity or information about decision making in the five care plans we reviewed. One person was unable to communicate verbally, although staff understood how the person communicated and made decisions, there was nothing in their care plan to inform staff about this. Another person who was living with dementia lacked capacity to make certain decisions. They lived with a family member but there was no information in the care plan to demonstrate what decisions they were able to make or who supported the person to make decisions in their best interest. The managers told us if a person lacked capacity to make decisions this would be recorded on the service proposal from social services. However, they acknowledged this had not been transferred to people's assessments or care plans. The registered manager said they would revise their assessment procedure to ensure consent and decision making was recorded.

The providers PIR told us, "We train all staff to meet the requirements of the Mental Capacity Act 2005 and its main codes of practice.... We audit by record and observation how staff comply with consent requirements." We found this to be correct. Staff we spoke with had completed training in MCA. They told us following recent training they had been provided with a booklet that explained MCA and how to put this into practice. However, two of the three care staff we spoke with had very little understanding of their responsibilities under the act. Only one of the three care staff were knowledgeable about the Act and knew this was about people's rights, consent and decision making ability. The provider and registered manager were surprised with this feedback, and told us all staff had received training and had their knowledge tested. They told us they would ensure all staff received further briefing about the MCA to increase their awareness. People we spoke with told us staff always asked for their consent before providing care.

We looked at five people's care records. An assessment of people's care and support needs had been carried out prior to people using the service to ensure the person's needs could be met by staff. People confirmed they were involved in the assessment process and felt their care support reflected their needs. Care plans had been developed from people's assessments. Plans included identified risks and informed staff what care and support people required and how they liked this carried out.

The managers told us they supported some people whose first language was not English. They were able to provide staff who spoke the person's language which enabled them to understand and meet the person's care and support needs.

We asked people if they thought care staff were competent and trained to meet their needs. Most people told us they were, for example, we were told, "The carers seem to know what they are doing when they support name." Another said, "I am not sure, I have never thought about it."

Care staff completed a range of training to make sure they had the right skills to meet the needs of people who used the service. Newly recruited staff undertook induction training when they first started to work for the service and completed the Care Certificate. (The Care Certificate is a nationally recognised set of standards to ensure staff have the right skills, knowledge and behaviours). The provider kept a record of staff training, the dates it was completed and when refresher training was due. Training records showed staff completed training which the provider considered mandatory for care workers. This included; safe handling and administration of medicines, moving and handling people (theory and practice), safeguarding adults and infection control.

Prior to this inspection visit we received some concerns about the service, which included care staff ability to move people competently using a hoist. We shared these concerns with the local authority and reviewed people's concerns during this inspection. One person told us, "They (staff) were unsure where the straps on the sling went so I had to show them." The managers were aware of this complaint and told us some hoists were different from the one used in training so staff usually asked the person to make sure they used the sling correctly.

Staff we spoke with and records of staff training confirmed, that staff completed training in moving and handling people which included a practical session for using a hoist, the use of different slings and slide sheets. Staff had regular observations of their practice through 'spot check's which included use of equipment.

People who required assistance with meals and drinks were supported to have sufficient amounts to eat and drink. Most people we spoke with were able to prepare their own food or had relatives who helped them do this. Where people required staff to assist them with meal preparation, this was recorded in their care plan. People who had assistance from staff to prepare their meals indicated they were satisfied with the service they received. For example one person said, "They prepare food that my [relative] has left which is usually a microwave meal or a sandwich. They always make a hot drink and leave me with a cold drink."

All the people we spoke with arranged their own health appointments or had family who supported them to do this. Staff told us, if a person was unwell during their call, they would ask the person if they would like to see a doctor and call the GP. They would also inform the family and contact the office staff to let them know, so they could follow this up if needed. Records showed health professionals such as GPs and district nurses were consulted where concerns had been identified.

Is the service caring?

Our findings

At our previous inspection we rated the service as good in caring. At this inspection, we found people continued to have their privacy and dignity upheld by care staff who were kind and caring. The rating continues to be good.

We asked people and relatives if they thought care staff were kind and considerate. People said they were. For example, "Such dignity and respect is given to [name], the carer is very gentle and very considerate." And, "Yes they are gentle, kind and respectful and we have a laugh and joke." People also said they or their family member felt respected and listened to.

Staff understood the importance of maintaining people's dignity. Comments from staff included, "When I am helping people wash I always make sure they are covered up as much as possible."

A relative told us, "I can't fault them the carers are really lovely, the other day they sang happy birthday to [name]."

Care staff told us they usually provided support to the same people to enable continuity of care, and to build up relationships and trust. Care staff we spoke with were familiar with people's preferences and how their support should be delivered. One person who had used the service told us, "I had the same carers who got to know me and who understood I was in a lot of pain, and were sensitive about this."

Supervisors who carried out observations of care staff in people's homes told us, as part of their observations they watched how staff communicated with people and if they were respectful. During the visit they would ask the person if they were satisfied with how the call was carried out, and if they were happy with their care worker.

People told us their cultural and religious needs were respected and met by the care staff. Some people told us their first language was not English and that some care staff could speak the same language. One person said "The carers are very respectful, and they are able to speak to me and my family in our first language."

Staff said they had sufficient time allocated to people's care calls and did not have to rush. Staff said visits were arranged in the same area so they did not have far to travel between visits. One staff member told us, "I always have time to have a chat and joke. I don't have to rush, people like to talk and we might be the only people they see all day." People confirmed staff did not rush and had time to sit and talk.

People were complimentary about the staff that visited them. One person told us about their regular care workers. "My carers Monday to Friday are like friends I even have their phone numbers in case I need anything." Another said, "[Care staff name] is absolutely wonderful, if the world was made up of [Name] it would be a better place."

People told us the service they received helped them to remain independent so they could remain living at

home. One person said, "The carers are very good to me. They come three times a day, I couldn't manage without them." Another said, "If I can do it I will, and the carers help me with the things I can't do."

Staff enjoyed their work and thought the management team were caring and valued staff. A staff member told us, "They [managers] do value us. [Registered manager] is great and is always willing to listen; she is like a mum to us."

People felt involved in their care, and were consulted about the care they required. One person told us, "I feel involved with the care I am given and the carers listen to me." Another person told us they were involved in writing their care plan.

Information about the service was available and accessible to people. People were provided with a home folder that contained information about the service and how it operates. Information provided to people also included the telephone numbers for the office, and how to make a complaint.

People's records held in the office which contained personal information were secured and kept confidential.

Is the service responsive?

Our findings

At our last inspection we rated responsive as good. At this inspection we found the service was not as responsive to people's needs as it had been at the previous inspection and improvements were required.

Since March 2017 we had received five complaints from relatives about inconsistency of care staff, the standard of care provided and late or missed calls. We referred the complaints to the local authority safeguarding team where required and shared the complaints with the local authority contracts monitoring team.

People we spoke with during our inspection reported similar concerns about inconsistency with call times and care staff, particularly at weekends or when their regular care worker was off work. For example, we were told, "Care workers in the week Monday to Friday are absolutely fine but it is hit and miss at weekends. Weekends are not good at all... I never know who is coming Sundays." One person told us how on occasion at weekends they had stayed in their chair, as they were unable to transfer into bed, because staff had forgotten to put the hoist on charge. The person had made a complaint to the provider about their service, and had informed us of their concerns which we had referred to the local authority for investigation. Another person told us, "The carers call four times a day and are not always on time. At weekends when the regular carer is off, if the carers are late it means a very long time in bed."

Other people had no concerns about their care workers or call times. One person who had recently used the service told us, "I had regular care workers. I was really grateful for the help and support." A relative said, "[Name] likes the care staff they turn up when they say and stay the time to do everything."

Everyone we spoke with said care staff stayed long enough to do everything people required.

We reviewed the call schedules for three people who used the service and for three care staff. These confirmed care calls were planned in advance and people were allocated regular care workers. We looked at three people's completed daily record logs that had been returned to the office. These showed staff mainly arrived around the time expected but did show times at weekends were sometimes earlier or later than planned. Some people told us not all care staff accurately recorded the times they arrived or left their home. The assistant manager told us staff electronically logged in and out of people's home on their work phones, so times staff entered and left people's homes were recorded and could be checked against the daily record log.

The provider and registered manager told us some people expected their care worker to arrive at the exact time each day, and that staff had a 30 minute leeway of the planned time to arrive at calls. Although some people we spoke with thought this was only 15 minutes.

The provider and registered manager were aware of the difficulty in continuity of staff at weekends due to care staff having days off. To improve continuity they had implemented an alternate weekend working rota for staff. They said the service also had staff who only worked weekends but when care workers phoned in

sick at very short notice it was difficult to arrange cover quickly. However all the staff in the office had completed the required training to provide care to people and were able to cover shifts if they were available.

People knew they had a care plan in their home for staff to follow. People's comments included, "The care plan is written in everyday and it is signed every time they [care staff] come." A copy of the person's care plan was kept at the office and contained details about their care needs and how the person wanted to receive their care.

We looked at five people's care records. Assessments of people's support had been carried out at the beginning of the service and care plans had been developed from people's assessments. Plans included identified risks and informed staff what care and support people required.

Not all identified risks had plans completed for staff to follow. For example, where people had been assessed as high risk on their nutritional assessment, the assessment stated a separate care plan was to be completed. On two care plans we reviewed where the person had been assessed as high risk a nutritional care plan had not been completed. Another person's care plan showed their medicines were to be given in liquid form and they required a soft diet. There was no information in the care plan to say why this was required. Where people had been assessed at risk of developing pressure sores, care plans instructed staff to check people's skin during personal care. Care staff told us they routinely checked people's skin to make sure it was in good condition, however, skin checks had not been recorded as completed on the daily records of calls we viewed. Where people required prescribed cream applied to prevent skin breakdown there was no body map completed to show staff where to apply the cream. The provider and registered manager told us they would ensure care plans were completed for all identified risks, and that staff accurately recorded the care provided to make sure people remained safe and received the care they required.

Care plans were reviewed at regular intervals or when people's needs changed. Care staff told us they reported changes about people's needs and conditions to the staff in the office, so that people could be reassessed and additional time could be arranged for visits if this was needed.

Some people told us they had difficulty understanding some staff whose first language was not English. An example of this was, "Some carers don't speak very good English so it's difficult for them to understand me and for me to understand them." We spoke with the administrator responsible for recruitment who said during the recruitment process they assess the applicant's verbal skills through face to face interview as well as their written skills to make sure they can speak English adequately, read care plans and complete daily records. The staff in the office and the managers said no one had raised concerns with them about care staff language skills. Following our feedback the registered manager said they would consider implementing a literacy test during recruitment. All the staff we spoke with during the inspection could effectively understand and communicate in English.

We looked at how complaints were managed by the provider. People we spoke with said they, or their relative would phone the office if they had any concerns. For example, "I would tell the carers and also the office." Another said, "I would ring the office and tell them, I would give them a chance to put anything right. I have not had to complain about this company." A relative told us they had raised a concern, and said, "I was happy with the way the complaint was managed."

Care staff knew how to support people if they wanted to complain. We were told, "There is complaints information in the folders in people's homes." Another said, "People have the phone number and know they

can phone the office at any time. They also have complaints information if they need it."

We looked at the record of complaints. The provider or registered manager had responded to formal complaints, and other concerns, and provided written responses to people with an outcome of their investigation. The provider had an 'issues' log where all concerns and complaints were recorded so they could quickly identify if there were any common trends or patterns.

Is the service well-led?

Our findings

At this inspection, we found the service continued to be led by an experienced management team who were committed to providing a good quality service. The rating continues to be Good.

People and relatives we spoke with said they were generally happy with the service they received and the care staff that visited them. People's comments included, "I am happy with the service offered to [name] I have nothing to complain about." "Immaculate Grace have been super, they have bent over backwards to help me." And, "I am happy, but I don't know what to expect as we have not used an agency before."

There was a registered manager in post who understood the responsibilities and the requirements of their registration. For example, they understood what statutory notifications were required to be sent to us, they had completed their provider information return when requested and a copy of their current inspection report ratings were displayed in the office as required.

The registered manager was supported by a management team that consisted of, the provider, an assistant manager, two care supervisors and an office administrator.

The provider had developed the management team since our last inspection. An assistant manager had been appointed and the role of senior care supervisor had been developed. Care supervisors had responsibility for observation of staff practice in people's homes, assessments and care plan reviews, and discussions with people about their care service. Senior staff felt well supported by the registered manager and the provider, they understood their roles and responsibilities and what was expected of them.

Care staff spoke highly of the management team and told us they were all approachable and knowledgeable if they needed advice. The provider and management team operated an 'open door' policy where staff could call into the office at any time.

Staff had regular supervision meetings to make sure they understood their role and spot checks to make sure they put this into practice safely. Staff said following spot checks they received feedback about their practice, both positive and negative so they could improve their performance.

When we asked staff what the service did well, all said communication from the office worked well and that they were able to speak with the managers about any issues connected with work or of a personal nature. Comments from staff also included, "We provide good care to people, we ask them what they want and we listen to what they say." And, "I really like the fact they ask us for our views on things, it makes you feel valued and involved."

Staff said, meetings were held to keep them informed of any changes in policies and procedures, and they had electronic copies of their rotas on their work phones that could be updated quickly if visits to people changed.

We asked people and relatives if the service was well managed. Most people thought it was. Although some people mentioned the service being short staffed due to staff leaving and late calls. Although we found no evidence that the service was short of staff, unless staff phoned in sick at short notice all visits to people were routinely allocated to care staff.

The provider and registered manager had identified through feedback from people that weekend calls were not as consistent as calls in the week and had taken recent action to fully implement the policy for staff working alternate weekends to improve consistency for people.

People told us there was usually someone in the office if they needed to speak with someone and that there was an 'out of hours' telephone service when the office was closed. Comments from people included, "The direct number is answered promptly." "The office staff are very polite, it is not often that I have to leave a message," and, "The office phone is not always answered when they are busy. The manager has given me their personal email and phone number to use."

People we spoke with said they would recommend the service to other people. They told us, "I would recommend the agency then it is up to people to decide if it is right for them. Everyone is different," and "Yes I would recommend them the carers are lovely."

The provider had procedures to monitor the effectiveness and quality of the service. The management team undertook regular checks of the quality of the service. When people's daily records were returned to the office, they checked records matched the care plans and that people's medicines administration records (MARs) were completed in full, to confirm people received their medicines as prescribed. The managers held regular management meetings to review the service and discuss any problems or improvements.

People's views were gathered in different ways which included quality assurance surveys, phone calls, care plan review meetings, and during spot checks on care staff while working in people's homes.

At the beginning of the year the provider and registered manager had set goals and objectives for the service which they monitored through an improvement and development plan. The provider also had an 'issues' log where any concerns and complaints were recorded, and monitored for any learning from trends and patterns.

In response to the concerns we referred to the local authority, commissioners carried out a monitoring visit in March 2018. The provider had completed an action plan to show how the service would address these concerns. At the time of our inspection visit in April 2018 the provider had started to implement the action plan to improve the service people received. For example, changes to the recording and monitoring of medication administration records, closer monitoring of the times of people's visits and implementing alternate weekend working for care staff.

The provider told us they kept up to date with good practice by subscribing to newsletters from National Institute for Clinical Excellence (NICE), Skills for Care, and quarterly reports from CQC. The provider also attended the local authority 'service providers' forum.