Local Solutions

Scotland Road Branch

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection of Local Solutions, Scotland Road branch took place on 7 and 8 December 2017 and was unannounced.

Scotland Road offices are the Liverpool branch of 'Local Solutions'. Local Solutions are a not for profit social enterprise, predominantly operating across Liverpool and North Wales. The organisation is a registered charity and provides personal care to people living in their own homes throughout Liverpool. At the time of our inspection the service supported approximately 770 people in the community and employed over 370 care staff.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in their community.

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.

At the last inspection completed on 27 January 2017, we found that the registered provider was in breach of Regulation 9 (Person centred care), Regulation 12 (Safe care and treatment) and Regulation 18 (Staffing). We also made recommendations in relation to governance and leadership. Following the last inspection, we asked the provider to complete an action plan to tell us what they would do and by when to improve. At this inspection, we found that improvements had been made and the provider was no longer in breach of regulation.

At the last inspection on 27 January 2017 we identified a breach of regulation in relation to safe care and treatment. This was because people did not have support plans in place around as and when required medication (PRN). At this inspection, we found that the registered provider had taken action and ensured that the relevant plans were in place around PRN medication to guide staff on safe administration.

At the last inspection on 27 January 2017 we identified a breach of regulation in relation to person centred care. This was because risks had not always been identified for people who needed support around

pressure care and manual handling. At this inspection, we found that risks were assessed and the associated care plans in respect of pressure care and manual handling were personalised and sufficiently detailed.

At the last inspection on 27 January 2017, we identified a breach of regulation in relation to staffing. This was because not all staff had undergone appropriate training to ensure they were competent and updated to train others. At this inspection we found the registered provider had taken action to update the training programme for quality officers to ensure those members of staff had the up to date skills and knowledge to support people effectively.

People who used the service told us they felt safe when receiving care and support.

Systems were in place to support people with their prescribed medicines. Staff received medicine training to ensure they had the skills and knowledge to safely administer medicines.

People were supported by sufficient numbers of staff. The majority of people told us that staff arrived when they should, were on time and stayed the correct amount of time.

We saw some people had experienced missed visits. The registered provider had taken appropriate responsive action and had analysed this information for possible trends or themes to help reduce the risk of reoccurrence.

People were protected from the risk of harm because staff could identify the potential signs of abuse and knew who to report any concerns to. Staff followed local safeguarding protocols if someone was deemed to have suffered harm.

The service operated within the principles of the Mental Capacity Act 2005 (MCA). Records demonstrated that processes were in place to assess people's capacity and make decisions in their best interests. Decisions that were made were thoroughly assessed to ensure the least restrictive option was chosen.

Staff were assisted in their role through induction, observations, supervisions and an annual appraisal and staff told us they felt well supported in their role.

Care records showed that people's health care needs were addressed with appropriate referral and liaison with external health care professionals when needed.

People were supported by staff in respect of their nutritional needs. People's records contained information relating to their individual dietary needs.

People told us they were happy with the care received and that staff supported them in a respectful manner. Staff spoken with demonstrated a clear understanding of their responsibilities and gave examples of how people's privacy and dignity was promoted and maintained.

People's care plans were person centred. Information we looked at described what the person liked to do and how they liked their routine to be followed.

People and relatives we spoke with said they were consulted about their care and we saw evidence of their input in care planning documentation.

Opportunities were provided for people, their relatives and staff to comment on their experiences and the

quality of service provided.

Complaints were well managed and documented in accordance with the registered provider's complaints policy. The complaints policy contained contact details for the local authorities and Local Government Ombudsman (LGO). People felt confident to raise any concerns and trusted that these would be responded to.

People, staff and relatives spoke positively about the organisation in general. People described the company as 'fantastic'.

The registered provider had sought new and innovative ways of improving service delivery such as the development of a pilot scheme entitled 'Cluster' and the acquisition of new electronic databases to improve operational efficiency.

The registered provider had a number of different systems in place to assess and monitor the quality of the service, ensuring that people were receiving safe, compassionate and effective care. Such systems included regular audits, analysis of complaints and missed visits and trend analysis in accordance with key performance indicators.

Staff meetings were held regularly and staff felt valued. This was promoted through initiatives such as 'Carer of the quarter' awards for staff, an employee recognition scheme which celebrated and rewarded good practice.

There were a range of policies and procedures in place to guide staff in their roles and these were updated regularly.

The registered manager had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding 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.

Risk assessments were in place for people who needed them. They contained a sufficient level of information and were reviewed regularly.

People felt safe and there were processes in place to help make sure people were protected from the risk of abuse.

Staff were safely recruited and deployed in sufficient numbers to meet people's needs.

Is the service effective?

Good

The service was effective.

The breach of regulation we identified at our last inspection on 27 January 2017 had been met.

People were supported by a staff team who received regular training and supervision for their role.

People's rights and liberties were protected in line with the Mental Capacity Act 2005 and consent was sought before delivering care. Mental Capacity Assessments were detailed and decision specific.

Where necessary people were supported in meeting their nutritional and hydration needs.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and treated them with dignity and respect.

People's preferences were reflected throughout care plans. This helped staff to get to know people and provide care based on their needs and preferences.

Care plans promoted people's choice and independence.

Is the service responsive?

Good

The service was responsive.

People's care records contained person centred and detailed information about the support they required.

People and their families were involved in the creation and review of their care plan.

Systems were in place to gather feedback from people and listen to their views. People were aware of how to make a complaint about the service and complaints were appropriately managed.

Is the service well-led?

Good

The service was well-led.

A range of quality assurance audits were completed regularly to monitor and improve service delivery.

Staff we spoke with were positive in respect of the overall management of the agency and the support provided by the management team.

The registered provider had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service.

Scotland Road Branch

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 registered 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.

Prior to the inspection we contacted the local authority quality monitoring team to seek their views about the service. We were not made aware of any concerns about the care and support people received. We also considered information we held about the service, such as notification of events about accidents and incidents which the service is required to send to CQC. We saw there was a significant number of 'safeguarding' incidents in the last 12 months and so decided to review the registered provider's response to safeguarding accidents and incidents as part of our inspection.

The inspection team consisted of two adult social care inspectors and two experts by experience who made phone calls to people who used the service and their relatives. 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 inspection took place on the 7 December and 8 December 2017. As part of our inspection, we spoke to two directors, the registered manager, the quality and assurance manager, the systems development officer, workforce development officer, a care co-ordinator and seven care staff. We also looked at 10 care plans for people who used the service, five staff personnel files, four medication administration records, staff training and development records as well as information about the management and conduct of the service. As part of the inspection we spoke with 25 people who used the service and two relatives.

Good

Our findings

On the last inspection on 27 January 2017 we found a breach of Regulation in relation to safe care and treatment. This was because risks had not always been identified for people who were prescribed PRN medication or for those people who needed pressure care and manual handling. This meant that staff did not have enough information to support people safely. Following our inspection the registered provider sent us an action plan detailing what action they were going to take and we checked this as part of this inspection.

We saw that people's care plans contained moving and handling risk assessments which were sufficiently detailed and provided specific and clear instructions on how to maneuverer people safely. We noted that risk assessments and management plans relating to moving and handling contained the necessary information in respect of people's height, weight, movement ability and the number of staff required to assist them. Step by step instructions were included to guide staff on the technique to be used, for example, the rolling technique and provided details on where each member of staff should stand and if there was anything to be aware of (such as a catheter). These assessments were completed by 'trusted assessors' if the level of manual handling complexity was high. Trusted assessors had received more advanced training in respect of moving and handling needs.

At this inspection, we found that medicines that were given as required when necessary (PRN) were managed effectively. The plans we reviewed identified why the medicines were needed and in what circumstances they were to be administered. They also contained relevant information on the effect of the medication and any further actions required. For example, if still in pain after 15 mins contact GP for advice. Having a PRN plan helps ensure safe and consistent administration.

People told us they felt safe when receiving care and support from staff. Comments included; "I feel safe because the care co-ordination is consistent and the carer calls at the appropriate time in the morning and evening; this aids my ability to function throughout the day because my care plan needs are met", "After having a stroke 12 months ago which resulted in falls, a carer calls three times a day, morning, noon and night and they are very helpful. As a result I feel much safer and have fewer falls" and "I feel safe because the carer makes sure I have my Zimmer frame available when I get up and move about and I find this encouraging because I can forget to use it."

At the time of our inspection, there were approximately 370 care staff employed to meet the needs of the 770 clients who received a service. People told us that sufficient staff were deployed to meet their needs. We

reviewed the rotas and saw that these were well organised and included travel time to promote punctuality. There was an out of hour's team, which consisted of a first response team who covered when care visits 'break down'. The service employed a mobile team of night carers, who visited people throughout the night to support them with continence care and pressure relief care.

People enjoyed continuity of care and this helped people feel safe. People commented; "I have the same carers", "Continuity is good" "Having a stable team is brilliant" and "Same staff so I can feel safe with them."

Consistency of care was promoted by the electronic call monitoring system in use at the service which was designed to record compatibility of staff and people receiving a service. Each staff member was allocated a ranking in order of preference based on how many hours they had previously supported the person. The office based staff told us they would endeavour to send the same member of staff in accordance with the order of preference.

The majority of people told us that carers arrived when they should and that time keeping was of a good standard. They told us if staff were going to be late, they were kept informed by someone from the office. Comments included, "Office always call me if the carers are late" and "On call always let me know if there is a problem." We spoke to one person who told us that their visits times could be inconsistent which impacted upon their quality of care. We brought this to the attention of the quality assurance manager and received immediate confirmation that a series of checks had been implemented to ensure this person was supported in a timely manner. This included the person's visits being moved to 'time critical' to ensure that their visits were prioritised and fortnightly monitoring of punctuality of the service being provided to the person.

Our review of the registered provider's records and through discussion with the management team, we identified that some people had experienced missed visits. We were told that the electronic system automatically logged visits as 'missed' if the carer had turned up significantly late to the visit. The registered provider had taken action to promote punctuality of visits by ensuring that carers were given travel time between visits.

We also saw that that the provider had learned lessons from these incidents. For example, we noted one incident whereby a staff member had been delayed due to having to wait for an ambulance in a person's house. This then impacted upon the staff member's next visits. The registered provider responded to this by implementing a new continuity procedure to guide staff on what to do in this event and at what stage arrangements should be made for subsequent visits to be covered by alternative staff. Senior care staff were trained to provide personal care and able to cover the rota if there were any care 'breakdowns'.

We also saw that the service had changed their co-ordinators shift patterns. This was to ensure there was a co-ordinator available to make supervisory decisions after business hours.

All missed calls were clearly analysed, with a reason for the missed visit, what happened as a result and what actions were taken to ensure this did not happen again. We saw that most missed visits did not result in harm occurring, however, we saw that safeguarding were appropriately informed in line with the local authorities processes.

Prior to our inspection, we had been notified about a number of different incidents which occurred at the service over the past 12 months, this included the number of referrals made to safeguard people's welfare. During our inspection, we discussed these incidents at length with the quality assurance manager. We noted that staff followed local safeguarding protocols and the relevant safeguarding referrals had been made to

the Local Authority. We saw that were safeguarding incidents had been substantiated, action plans were drawn up and responsive action was taken. For example, we saw that some staff had been disciplined as a result of medication errors and re-training had taken place.

During this inspection we looked at how staff supported people with the management and administration of their prescribed medicines. People told us; "They make sure I get my medication, I'm alright with everything else, they are very good and take an interest in me."

A medication policy was in place and staff who administered medicines had received training to ensure they had the skills and knowledge to administer medicines safely to people. We saw detailed guidance within people's care plans in respect of their medical history. There were records in place to track whether people had been administered topical preparations (creams) and body maps which recorded the areas of the body the cream was to be applied to.

We reviewed five Medication Administration Records (MARs) and saw these were completed accurately. Regular audits were completed by quality officers in respect of MAR's and where inaccuracies were identified, appropriate action was taken. This included a letter of concern being sent to staff with a copy of the medication policy for their review.

Staff completed risk assessments to assess and monitor people's health and safety. We saw risk assessments and management plans in areas such as falls, manual handling, pressure care and nutrition. Each care plan contained task and situational risk assessments which showed the relevant risks, control measures and how to mitigate the risks associated in respect of each individual task staff were required to complete; such as medication administration and personal care.

Each care file contained an environmental risk assessment which had been completed on each person's home during the initial assessment process to highlight any potential hazardous working conditions for staff such as pets or stairs. Action had been taken to minimise risk to both staff and the person they supported. For example, one person's pet was identified as a trip hazard and agreement was sought from the person's family to remove the pet from the room whilst staff provided support.

We reviewed five personnel files of staff who worked at the service and saw there were safe recruitment processes in place including; photo identification, employment history, two references and Disclosure and Barring Service (DBS) checks. DBS checks are carried out to ensure that staff are suitable to work with vulnerable adults in health and social care environments.

The service had infection control policy and procedures in place. These provided staff with guidance on the prevention, detection and control of the spread of infection. Staff spoken with confirmed they had completed training and had access to personal protective equipment such as gloves, where this was needed. The care records showed that staff had appropriately identified a risk of infection whilst undertaking personal care and the control measures to mitigate this risk were recorded and included the use of personal protective equipment.

Good

Our findings

On the last inspection on 27 January 2017 we identified a breach of Regulation in relation to staffing. This was because staff had not always received the appropriate training to be able to deliver effective care for people. This was related to manual handling training and other specialist care such as stoma care. Following our inspection the registered provider sent us an action plan detailing what action they were going to take and we checked this as part of this inspection.

We reviewed documentation which showed that the relevant staff from our last inspection had recently accessed an accredited training course for moving and handling people, risk assessment and bariatric training in January 2017 in accordance with the registered provider's action plan. We reviewed the registered provider records which showed that 89 members of staff had now received training to support people with stoma care needs. This equated to around 25% of the workforce. The service also employed a nurse practitioner on a sessional basis to provide clinical input and deliver in house refresher training in specialist areas such as stoma care and pressure care monitoring.

People told us that carers had the necessary skills to support them. Comments included, "The staff know what they are doing, very happy"; "Training seems consistent" and "Very efficient carers."

The quality and assurance manager provided us with a staff training matrix and we viewed certificates within staff recruitment files which demonstrated that staff had received training in topics such as mental capacity and mental health, dementia and medication administration. Some staff had received additional training in relation to diabetes and epilepsy awareness. Senior staff also received specialist training in areas such as PEG regimes. Each person's care file contained a service user priority and specialist training checklist to ensure that staff responsible for the provision of care were able to meet the person's needs.

Staff told us the registered provider was responsive to requests for further training and promoted ongoing training and development for staff. We spoke to the workforce development officer at the organisation who told us "If I identify training needs, I contact our training department and they arrange it."

Staff reported feeling well supported in their role through induction, supervisions, personal development reviews and annual appraisal. We reviewed the registered provider's supervision schedule and saw that all staff had regular observations, office based supervisions and work based supervisions. Supervision sessions between care staff and their manager give the opportunity for both parties to discuss performance, issues or concerns along with developmental needs.

The registered provider maintained links in the local community with other providers, local commissioning groups and attended conferences to share good practice. Staff told us they worked collectively to help deliver effective care and support.

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.

The records that we saw indicated that consent to provide care had been sought in accordance with the principles of the Mental Capacity Act. Peoples care plans contained documents entitled 'How I consent to my care' and details on how care planning consent was obtained was recorded in people's files for example; by visit to the person's home.

Care files included Mental Capacity Assessments to prompt staff to consider whether people had capacity in accordance with the four stage legal test; that is, can the person; understand, retain, and weigh the information and communicate their decision. If the person was unable to do any of these, then the person would lack capacity to consent to that particular decision. These assessments were decision specific, in accordance with the principles of the Mental Capacity Act 2005.

Where people were assessed as not having capacity to make a particular decision, consultation was held with family members or healthcare professionals and a decision was made in their best interests. This process was used in respect of decisions around personal care, meal preparation and medication. We observed that there was a clear and detailed rationale as to how staff made these decisions. This was referred to in peoples care plans as determining the least restrictive option. Three options were documented, two were disregarded with the reasons for this explained, and one was agreed upon as the chosen best interest process.

We saw that some people had not signed their care plans themselves, despite them having capacity. Some files contained a caveat that the person did not sign because due to physical weakness but one file did not have this qualification so we raised this at the time with the registered manager. People's lasting power of attorney was clearly recorded in files and supporting evidence of this was also included.

People told us that staff obtained consent before delivering care. People told us staff ask, "Do you mind?" and this was done in a caring manner. One person's relative told us, "They always ask and tell my mum what they are going to do."

Staff had regard for people's nutritional needs and supported them where required. Care plans included food and drink management plans and nutritional supplement plans. People told us, "I'm always asked what I would like to eat or drink." People's relatives also told us, "They [staff] always leave a drink" and "They will offer a choice of meals."

Care files contained reminders such as, 'care staff to monitor person's nutritional intake and report any concerns of weight loss to the office immediately'. We saw that people who required specific support with dietary needs, such as pureed or fork mashed food, had this written up in their care plans, with guidance and input from a speech and language therapist. We identified one care file whereby a person's requirements for a soft diet was not highlighted at the beginning of the care plan and we discussed how to make this information more visible to staff.

We saw that detailed information was recorded to guide staff on how to support people who received nutrition via a percutaneous endoscopic gastrostomy (PEG) tube (given through a tube inserted into a person's abdomen into their stomach.) The regime of how to support people to eat contained clear step by step instructions in accordance with the advice from the community nutritional support dietician.

People using the service were supported by staff and external health care professionals to maintain their health and wellbeing such as Liverpool Community Health, dietician and the Speech and Language Therapist. Care files contained contact details for people's GP and other health professionals involved in their care. Staff told us they would call a doctor if people were unwell.

Good

Our findings

People told us that the carers who visited were all very caring and would always ask them how they were feeling and asked them what they would like help with. Comments included, "Very caring staff, cannot do enough for me", "Office staff are lovely", "Wonderful care staff", "Really happy with my carers", "Very genuine carers" and "They really do care."

People told us staff were respectful and promoted their dignity. Comments included; "They most definitely respect and protect my dignity especially when I am receiving personnel care, they respect me as an individual and for who I am" and the "Staff respect me and my home."

Staff spoke of people they supported in a caring and compassionate way. They were able to demonstrate their knowledge of people and tell us what was important to people, their likes and dislikes and the support they required.

Staff discussed the ways in which they preserved people's dignity and privacy. One staff member told us they provided care discreetly to a person and ensured their family members were not present when delivering personal care. Other examples provided by staff included covering people with a towel when supporting them with washing and closing blinds.

People were actively involved in making decisions about their care and support. Care files contained documents entitled; 'Summary of me and how I would like you to support me'. People told us that the staff were responsive and allowed them to express their views. Comments included; "Staff and office staff listen to my needs" and "They always ask if I need anything else."

Staff encouraged people to maintain their independence and offered support and encouragement when needed. One person told us, "The staff encourage me to make decisions." Another person described how staff supported them with shopping and swimming which made them feel included in society and helped them to maintain contact with friends.

Staff had received training in relation to quality and diversity and the registered provider had an equality and diversity policy in place. Equality and diversity considerations were written into people's care plan, and we saw some good examples of this, for example, one care file documented; 'Please ensure my curtains and blinds are drawn before you provide my care.'

Details of advocacy services were circulated to people using the service. Advocacy services represent people where there is no one independent, such as a family member or friend to represent them.

Good

Our findings

On the last inspection on 27 January 2017 we identified a breach of Regulation in relation to person centred care). This was because the manual handling care plans lacked detail and people with pressure care needs did not have a risk assessment in place. This meant that staff did not have enough information in respect of people's individual needs. Following our inspection the registered provider sent us an action plan detailing what action they were going to take and we checked this as part of this inspection.

At this inspection, we reviewed moving and handling plans within care files. We found these were detailed and included specific and clear instructions on how to maneuverer people safely. We viewed pressure care risk assessments and the associated management plans within care files. These documents outlined whether the person had a history of pressure sores, their mobility level and whether they were at risk of malnutrition or if they had a sensory or cognitive impairment. Management plans included advice to staff in respect of nutrition and hydration support, reminders regarding the need for observation of changes to skin condition and impact on the person if care was not delivered as per the guidance. Details of the pressure relieving equipment people used was also recorded.

People told us the agency was very responsive to their needs. People told us that they and their family were involved in the care planning and were given choices in relation to their care delivery. Comments included, "I was involved in the care plan and reviews" and "Care plan was very good, I was involved in all the planning." People's relatives were also consulted in respect of the development and review of their loved one's care plan. Comments included; "I was involved in the care planning", "I am involved in the planning of the care and can call the office if I have any concerns" and "I can speak to the office with any change in [relative's] care needs."

Care files contained pre-admission assessments which were detailed and contained information in respect of people's medical needs such as pressure sores, or problems with memory or confusion. This ensured staff were aware of people's needs from the outset.

Each plan contained an outcomes form completed with the person regarding their expectations of the service and how they wanted to be supported. These were regularly reviewed and people had a copy of their care plan in their home. Care plans were signed by people (if they had capacity to do so) to support their inclusion in the planning and delivery of their care.

Support plans provided detailed information about people's health, communication and the way in which

they wanted their support delivered. This information was person centred and an individual personal profile was available which contained information around people's routine and personal preferences. Person centred means based around the needs of the person and not the service. A breakdown of people's call time stipulated how people wanted to be supported and clear guidance was contained as to what staff should do on each call. For example, 'please come into my room and say hello to me.'

A personal profile provided information on people's social history, past relationships and previous job. This enabled staff to understand the background of the person and promoted rapport building between staff and the people they support. People's communication needs were also recorded within care files so that staff could converse effectively with the person. For example, one care file reminded staff to 'ensure to face client when communicating as they do not wear glasses and has glaucoma'.

The majority of people told us that staff were not task orientated and took time to have a chat. People told us staff made an effort to know their likes and dislikes for example, how they liked to have their tea. Another person told us, "Yes they take good care of me and take an interest in what I am doing this includes my interest in Sci-Fi and Facebook, this encourages me to maintain an interest in hobbies and maintain a level of social interaction and independence."

People told us they could choose whether they wanted a gender specific carer. This preference was clearly recorded on files and the electronic system. One person told us, "I have the choice of carer, because I am a woman I can choose a female carer, it makes me feel less vulnerable to abuse especially when I am being washed and dressed."

People told us they knew how to make a complaint about the service. Comments included; "I can safely say these are few and far between", "Any concerns I would call the office and "Any complaints are dealt with." The registered provider had a detailed complaints policy in place to support people to raise concerns about the service which included details for the local authority and the Local Government and Social Care Ombudsman. We reviewed a selection of recent complaints and saw these were related to a variety of issues such as staff conduct, missed visits, punctuality and missed medication. We saw that complaints were recorded and actions were taken as a result. For example; communication training for staff or office based supervision to address the concerns identified. These were also analysed in relation to month, nature of complaint and workgroup in order to analyse trends and reduce the risk of reoccurrence.

People also told us they could raise any issues or queries informally and felt confident that these would be responded to. Comments included; "Any issues I call the office and they will help me", "If I call the office I find the staff very helpful", "I feel listened to" and "I feel valued." People's relatives echoed these comments and told us, "Any concerns I call the office and [I'm] confident they will listen and take action" and "I call the office and they will take on board my comments."

We saw that where people had raised concerns regarding a specific carer, the service had responded by ensuing that person was not allocated to them. This was clearly documented on the electronic system and meant that the carer could not be scheduled to attend to the person. One person's relative also told us the agency was responsive when they raised concerns regarding a specific carer and took action by ensuring that staff member was not sent to their relative again, "I have called the office with a staff member problem and they have sorted it for me."

The service supported people at the end of their lives. Some staff told us they had received training in palliative care. We saw evidence of 'Do Not Attempt Resuscitation' (DNAR) forms within files in accordance with people's wishes. Some files also contained information in respect of people's advance decisions or

statements of wishes/preferences in respect of end of life care.

Good

Our findings

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.

People told us they felt the organisation was well-led and that staff were very efficient and approachable. People's comments included; "Amazing company", "Cannot fault the agency", "The team is fantastic" and "One of the best agencies." One person's relatives told us, "The whole company is excellent."

Quality assurance procedures were robust and audits were completed regularly and in a wide range of areas to monitor and review the quality of service people received. Regular audits were completed in respect of people's electronic care files and where problems were identified, for example, in respect of staff recording, action was taken. This included discussions around record keeping within people's supervision sessions. We reviewed documentation which showed that senior care staff completed regular observations and work based supervisions to assess the quality of care being delivered by care staff.

The registered providers own quality progress reports were completed every six months. We reviewed the records relating to April 2017 until September 2017. We saw that safeguarding's, accidents, complaints and missed visits were presented in a table with an accompanying graph to show how the statistics compared to other areas. For example, we saw that 96% of complaints to the service had been responded to. Also, out of 32 safeguarding incidents, seven were found to be substantiated.

The local authority had completed their own contract monitoring auditing of the service twice since our last inspection. We saw that action plans had been set for the registered provider and the scores for these visits after the actions had been completed had risen from 88% to 95%.

The registered provider had identified that the service were not currently meeting their own key performance indicators for missed visits. We saw that missed equated to approximately 1% of the total hours delivered however the registered provider had recognised this as an area for improvement. The registered provider completed their own quality assurance checks in relation to these, and we saw that they had decreased in the last few months. In June, the number of missed visits peaked, and we saw a detailed explanation from the quality assurance manager explaining the reason for the increase in missed visits, and what remedial action had been taken such as disciplinary action for staff.

We reviewed the registered provider's business plan and strategic objectives from 2017 – 2020 which identified the need for improvement in the current system with regards to electronic call monitoring. The provider had recently acquired two new electronic care management systems named 'One touch' and 'Pass'. This was in response to some of the complaints and safeguarding's which the organisation had investigated over the last 12 months. They found complaints often related to missed visits which they attributed to system failures and staff not always doing what they were supposed to on the visit. The acquisition of the new system showed that the service was responsive to people and using feedback to improve service delivery.

The systems development officer showed us how these two new systems operate and we saw these were user friendly and effectively designed to meet the individual needs of people receiving care. Features of the new system included the ability for staff to update electronic records in 'real time' as they delivered tasks and the ability to log in and out of calls without having to use people's landline. At the time of our inspection, the systems were not yet fully embedded and were in the process of being rolled out on a phased basis. We were therefore unable to measure any improvements to the service but the registered provider agreed to keep us updated with their progress.

The registered provider told us of their innovative plans to improve service delivery in the local area and deliver effective care and support by working collectively with local authorities and local hospitals. One pilot scheme entitled the 'cluster' service involved the deployment of 10 staff to target support in areas which required urgent delivery of care to meet people's needs more promptly and responsively, such as hospital discharges in the Liverpool area. The 'cluster team' would provide care in the first instance to these people whilst permanent care staff were recruited. The cluster team would then move on to create another 'run' (which is a term used to describe visits close to one another) in the next area identified with high demand.

We saw evidence of regular team meetings being held between quality staff, care co-ordinators and care staff. The agenda covered topics such as long working, confidentiality and developments at the service in respect of the IT systems. Staff meetings were held at different locations and alternative dates to encourage staff participation. Staff engagement was also promoted by the registered provider's agreement to pay staff for their time to attend. Staff described the management as approachable. One staff member told us, "I have no qualms about going to management." Staff described the new registered manager as 'supportive' and felt they could access advice and guidance from a number of people in the management team when needed. Staff told us they were also able to raise any issues informally.

We observed, and heard how good practice was recognised and celebrated in the organisation through an initiative entitled 'Carer of the Quarter' whereby staff were rewarded for good practice. The registered provider also held 'Carer of the Month' events. The minutes from these events suggested staff were asked to consider, 'How can we make you feel more valued?' The feedback from these events suggests carers felt valued in their role. This feedback was also compiled and used to develop the service. For example; a summary of training needs was drawn following staff request for further training.

The agency had a system in place to gather the views and opinions about the service from the people who received the service or their relatives. Quality assurance surveys were circulated and they were able to respond anonymously via a freepost envelope or online. We also saw evidence that the registered provider completed telephone quality assurance surveys on a cross section of people receiving a service each month. People were asked to rate their satisfaction levels of the service. We saw that the majority of respondents answered positively to the questions and the data showed that 90% of respondents said the service provided by Local Solutions was good.

We saw the registered provider had a range of policies and procedures which were updated and reviewed regularly in topics such as safeguarding and electronic call monitoring. There was an informative flow chart in place to guide senior carers and which clearly explained the process they should follow if someone raised a concern, safeguarding incident, complaint, or accident.

The registered provider had notified the Care Quality Commission (CQC) of events and incidents that occurred at the service in accordance with our statutory requirements. This meant that CQC were able to monitor risks and information regarding the Scotland Road branch of Local Solutions.