Nestor Primecare Services Limited

Allied Healthcare Redcar

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection took place on 17, 24, 26 October and 2 November 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to assist us.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger adults with a physical or mental health disability, and children. At the time of the inspection, 111 people were using the service and were supported by 53 active staff members.

Not everyone using Allied Healthcare Redcar received the regulated activity of personal care; At this service CQC only regulates and inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where people were not in receipt of such care, the Commission takes into account any wider social care provided.

The service was last inspected by CQC in August 2016, at which time the provider was found to be in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. During that inspection we found the provider did not ensure the proper and safe management of medicines. Risk assessments did not reflect people's needs and people's risks had not been regularly reviewed. Staff did not always act upon risks when they were identified. Care records did not always match people's needs. We found they were not regularly reviewed. We also found that not all staff had received the appropriate training and supervision support.

At this inspection we found improvements had been made and the provider had completed each of the improvement actions necessary. Care records had been improved and of the records we reviewed we found they were accurate and up to date. Training of staff had been addressed in relation to safeguarding and the Mental Capacity Act 2005 and improvements had been made. In addition to the above, staff now received regular supervision and checks on their competency. We saw that for those people with clinical needs such as pressure area care, risk assessments could be further improved and more detail was needed to ensure staff members were following safe infection control practice. We have made a recommendation about risk assessments.

The service had a registered manager in place. 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.

We found the arrangements for medicines management kept people safe. We looked at the medicine records of nine people who used the service. We spoke with staff about medication and reviewed the provider's medication policies.

People who used the service told us they felt safe and relatives said they had confidence in the ability of staff to keep people safe. Staff had received training in safeguarding and understood their responsibility to protect vulnerable adults from harm and improper treatment. There was an out-of-hours phone line through which people could seek assistance from the service in case of unforeseen circumstances. People reported they had not experienced any missed calls recently.

Risks were assessed by an area supervisor when someone first started using the service, and reviewed thereafter. Pre-employment checks for new staff members, including Disclosure and Barring Service checks, were in place.

There were sufficient numbers of staff on duty to meet the needs of people who used the service. People we spoke with told us staff stayed their allocated time and they were usually informed if their care worker was running late. A new electronic rota system using mobile phones had been recently implemented and we were told this helped prevent missed calls and meant staff were allocated in a more systematic way.

New staff received a seven-day induction, as well as shadowing opportunities. We found mandatory training covered a range of core topics, such as: safeguarding, infection control, dementia awareness, first aid and nutrition. The registered manager ensured staff completed refresher training.

Staff liaised regularly with external healthcare professionals and ensured their advice was incorporated into care planning.

Staff were supported through annual appraisals and a number of supervisions and observations throughout the year.

People who used the service and relatives consistently told us staff were caring, patient and upheld people's dignity. People confirmed staff encouraged them to retain their independence on a day-to-day basis.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us they were encouraged to contribute to their own care planning and review, and felt partners in the process.

People who used the service and external professionals told us staff were accommodating to people's changing needs and preferences.

People who used the service knew how to complain, and who to. This information was shared with people in a welcome pack. Complaints were thoroughly investigated and responses given and feedback about lessons learnt was shared with the staff team.

The registered manager and care staff were described in positive terms by people who used the service and relatives. The registered manager had worked to make improvements since our last visit and feedback from people and staff was that the service had improved. Auditing and quality assurance systems were in place to enable the provider to identify trends.

The culture of the service was in line with the goals of the statement of purpose, meaning people who used the service were supported to maintain their independence from care staff who demonstrated a good understanding of people's needs and individualities.

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.

Risk assessments for people with complex healthcare needs needed to be more detailed to ensure people's conditions were appropriately described and assessed.

Medicines were managed safely.

People told us they felt safe. Staff we spoke with were aware of the different types of abuse and what would constitute poor practice. Staff knew how to recognise and respond to abuse correctly.

Pre-employment checks of staff ensured the risk of employing someone unsuitable to work with vulnerable people was reduced.

Is the service effective?

Good

The service was effective.

People who used the service told us they received the support they needed in a timely way.

New staff received a range of mandatory training and shadowing support prior to supporting people who used the service.

Staff received regular appraisals, whilst the supervision process now included more practice-based observations.

People told us they were supported to prepare food and drinks of their choice which helped to ensure that their nutritional needs were met.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service was responsive.

People's care and support needs had been assessed before the service began.

Care records we looked at detailed people's preferences, goals and needs. Staff and people who used the service spoke about how they received person centred care.

The service responded to the changing needs of people and reviewed their care and progress with them regularly.

We found effective processes were in place for listening and learning from people's experiences, their concerns and complaints.

Is the service well-led?

Good

The service was well-led.

Audits were now in place to address the deficits in the quality of the service we found during our inspection in August 2016.

Staff and people told us there had been improvements at the service since our inspection in August 2016.

The service had submitted the required notifications to CQC and had displayed its rating at the service.

Allied Healthcare Redcar

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.

The inspection took place on between 20 October and 2 November 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us. We visited the office of the service on 20 October and 2 November, and also carried out telephone interviews with people using the service and care workers on 24 and 26 October 2017.

The inspection team consisted of one adult social care inspector, a pharmacist inspector and three experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who used this type of care service. The experts in this case had experience in caring for older people, people living with dementia, people with physical disabilities and people with mental health needs.

Before our inspection we reviewed all the information we held about the service. We examined the previous action plans sent to CQC by the provider and notifications we had received. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with two staff from local authority commissioning and safeguarding teams. We spoke with the local Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services. We used this feedback as part of our inspection planning process.

We asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

During the inspection we reviewed eight people's care information, nine people's medicine records and looked at a range of staff records, policies, procedures, auditing, rota information, survey information and IT systems. We spoke with 42 people who used the service and three relatives. We also spoke with 11 members

of staff which included the registered manager, two care co-ordinators and eight care staff.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in August 2016 we identified concerns that the provider had not managed medicines in a safe manner, risk assessments were not always in place and safeguarding alerts had not been made appropriately.

We saw risk assessments were completed during the first visit by a care co-ordinator, highlighting any obvious areas of risk, such as trip hazards and electrical risks. We also saw risk assessments specific to people's individual conditions and needs were in place and these were reviewed regularly, or when a change occurred. Staff we spoke with demonstrated a good understanding of the risks people faced and how they helped people minimise these risks.

We found that in two risk assessments we reviewed, one for a person with a catheter fitted and another for a person with skin pressure issues, further detail needed to be recorded to ensure that the service recognised and recorded the exact health issue. For example, for the person with skin pressure issues, the exact grading and description of the wound was not recorded nor a body map completed showing the exact site of the wound. We discussed the two risk assessments with the registered manager who stated they would review these documents immediately.

We recommend that the provider considers current NICE guidance on clinical issues such as skin integrity, catheter care and diabetes, to ensure people's healthcare needs are accurately recorded and monitored. The National Institute for Health and Care Excellence [NICE] guidance make evidence based recommendations on a wide range of topics, from preventing and managing specific conditions, improving health, and managing medicines in different settings, to providing social care and support to adults.

We found the arrangements for medicines management kept people safe. We looked at the medicine records of nine people who used the service. We spoke with staff about medication and reviewed the provider's medication policies.

Care records were audited annually; each record contained the consent form, which detailed the level of medicines support required. A medication plan was written for each person detailing their support needs and preferences for how they liked to take their medicines. These were however sometimes generically written and lacked detail surrounding individual medicines requirements. For example, two people attended community centres twice a week yet this was not referenced in their care plan and the method for ensuring medicines were taken was not recorded. Staff told us that the medicines were taken with them and were taken at the community centre but this was not recorded clearly in the plan or the medicine administration record (MAR). A medication risk assessment was completed and this was present in all folders looked at. The registered manager told us they would review records related to medicines support to ensure that they were sufficiently detailed and reflected all aspects of people's individual medicines support requirements.

We found the administration of people's prescribed medicines was clearly recorded and non-administration

codes were used correctly however for medicines which were not administered the reason for not giving the medicines was not clearly documented. For example, one person's medicine had been discontinued by the prescriber, however, care workers had recorded none available on the MAR. We discussed this with staff during the inspection and they stated that actions would be taken to increase communication regarding changes in medicines.

When care staff were required to make changes to MAR charts, such as when the strengths and dosages of medicines changed, there was a system of second checking in place by another staff member to ensure any hand written entries were accurate for staff to follow.

Care staff applied creams and ointments to many of the people whose records we looked at. Body maps were in place for all of the people we looked at and these contained sufficient detail to ensure staff knew how, where and when to apply the creams or ointments. If multiple preparations were to be used then different body maps were produced and it was clear which map referred to which product.

We looked at the guidance for staff about medicines to be administered 'when required.' The guidance stated there should be a specific plan for administration; however, we found that this guidance was missing for the three people's records we looked at who had been prescribed medicines to be taken 'when required'. We brought this to the attention of the registered manager who stated this would be rectified immediately. Not having sufficient information increases the risk of the person's medicines not being administered correctly and therefore experiencing a decline in their health or wellbeing.

A system of audit was in place to ensure a regular check of MARs. Every three months each person's record was audited. We saw how this audit was completed. Although issues highlighted in the audit were addressed, at the time the audit occurred the service did not look at overall themes and trends. Information from individual audits was communicated through meetings and competency assessments.

We spoke to people about their medicines. One person who used the service told us, "I have them in a box. I think she [staff] puts it in a black book." Another person told us, "I see them writing it in the care book." Relatives we spoke with similarly raised no concerns about the administration of medicines. One staff member told us, "I will always administer medication following the MAR [Medication Administration Record] chart and also body maps if this is required. I will follow the six R's which are right patient, right medication, right dose, right time, right route and right documentation." This demonstrated the provider had sought guidance about appropriate and safe management of medicines and staff were knowledgeable about how to support people safely.

Safeguarding training was delivered as part of the provider's induction and staff had received refresher training on this topic. When we spoke with a range of staff they were clear about their safeguarding responsibilities and how they could raise concerns.

External professionals agreed they had more generally seen a decrease in serious safeguarding issues occurring and that, where there were concerns, the provider was more proactive in raising these and alerting the appropriate agencies. We saw incidents and accidents were consistently recorded and these were also regularly analysed by the registered manager.

People who used the service and their relatives told us they felt safe in the presence of staff, and that they were trustworthy and sufficiently skilled to keep them safe. One person said, "I have never felt unsafe. I have never really thought about it," and another person said, "I get upset, they calm me down." One relative told us, "My relation feels very safe with them. She felt very vulnerable on her own."

People cited staff following good infection control practices as an example. One person told us, "They [staff] always wear both gloves and aprons." Another person told us that staff would, "Wash hands before attending. They are great." We saw the provider delivered infection control training during the induction, had there was ample personal protective equipment (PPE) available on site. When we reviewed care plans we noted that there was not always sufficient detail about the disposal of continence items or dressings. We asked the registered manager to ensure care plans were enhanced to ensure staff knew exactly how to dispose of items they may present an infection risk in a safe and appropriate manner.

We saw a range of pre-employment checks were in place, such as Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they may present a risk and it also stores and shares criminal history information for when relevant employers request this. Other pre-employment checks included gathering references from previous employers and exploring any gaps in employment. This meant staff were subject to suitability checks prior to working with potentially vulnerable individuals.

There was an out of hours team who took calls from staff and people who used the service should they encounter unexpected problems outside of office hours. People who used the service confirmed they knew who to contact in an emergency and we saw this information was made available to people in the welcome packs they were given.

Care co-ordinator staff monitored the care visits staff were due to carry out and contacted staff members who had not logged in to a given call, to ensure that people who used the service, and staff, were safe. We found staffing levels to be sufficient to keep people who used the service safe and no-one we spoke with had reported any missed calls.

The provider had lone worker training and a suitable policy in place, and a new electronic log in and rota system via mobile phones which ensured the office staff knew where care staff were at all times. No staff we spoke with raised concerns about how they were supported as lone workers.

Good

Is the service effective?

Our findings

At the previous CQC inspection in August 2016 we identified concerns that the provider had not ensured all staff were appropriately trained to meet the needs of people who used the service, mental capacity assessments were not always in place and staff were unaware if people had DNACPR records in place. At this inspection we saw improvements had been made and staff had the relevant training to help meet people's needs. We saw the induction training included sections on dementia awareness, safeguarding, infection control, health and safety, moving and handling, fire safety, nutrition, dementia, catheter care, diabetes awareness and pressure sore awareness. The training was delivered over a six-day induction period and feedback from staff was positive regarding the induction preparing them for their roles.

When we asked staff what was the best thing about working for the provider, one staff member said, "The training was good. I attended a three day training course which consisted of management of medication, moving and handling, dementia, first aid, catheter and stoma healthcare tasks and keeping customers safe. I then had a further three days completing mandatory e-learning training courses online." A significant majority of people who used the service and their relatives were in agreement about the capabilities of staff who supported them. One relative stated, "Yes they use the hoist. I have training so I know they are good." Another person told us, "Yes, they use slide sheets and lifting equipment, they are definitely trained."

Staff training needs were regularly monitored by the registered manager meaning people received care and support from staff who benefitted from well-planned training provision. When we spoke with staff they were able to describe the training they had received and how it was relevant to their care roles. One staff member told us, "Recently I have had stoma and catheter care training, dementia awareness, diabetes awareness and my general induction training."

We saw the induction for new staff included shadowing more experienced members of staff. People we spoke with told us new staff were usually introduced to them by experienced staff members who knew them well.

The majority of staff we spoke with felt supported in their role, whether through peer support or support from their care co-ordinator. Staff told us they had annual appraisal meetings and intermittent supervision meetings. We saw that staff members were also assessed in practice and this included through induction. We saw feedback was given to staff members with examples such as, "Listened well and asked questions, wasn't afraid to talk to customers and offered good choices." Staff we spoke with who had experienced this revised form of supervision were positive about it. One staff member said, "I have support from fellow carers, office staff and line managers as well as other health care professionals."

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. People can only be deprived of their liberty to receive care and treatment when this is in their best

interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA, and whether any authorisations to the Court of Protection had been made. The registered manager told us at this time that they had not. The registered manager and staff we spoke with told us they had attended training in the Mental Capacity Act (MCA) 2005. We saw assessments of people's mental capacity had been undertaken and recorded by the service. We discussed with the registered manager that the service should ensure where a person had Power of Attorney regarding another person's finances or care and welfare, evidence of this was seen and recorded within the person's records.

In the care files we reviewed we saw people had consented to the care planned. When we spoke with people they confirmed this to be the case. One person said, "They always ask before they do anything." Others confirmed that staff asked for their consent when performing individual aspects of care, such as administering medicines or helping someone with aspects of personal care.

With regard to nutrition, we saw each care file had a specific nutrition section and, when we asked people about this aspect of care, they provided positive feedback about staff. One person said, "They ask what I want and I tell them." One person's relative told us, "They always note down what she has eaten."

Good

Is the service caring?

Our findings

People who used the service and their relatives gave consistently positive feedback about the caring attitudes of staff. One person who used the service told us, "They [staff] treat me with respect, they are very respectful." Another person told us, "They chat with me all the time. It's very revitalizing." Relatives we spoke with were positive about the relationships staff had formed with their relatives within the context of supporting them, stating, for example, "We treat them [staff] as friends they are as good as that," and, "The care is exceptional in every way and the carers are gentle and kind and not bossy and ordering my parent to do things."

We asked people about whether they felt care staff were able to achieve a balance between completing the tasks they needed to and still treating them with patience. Whilst a small number of people felt staff were sometimes rushed and were overly focussed on tasks rather than them, a significant majority of people provided positive feedback, for example one person told us, "If there is nothing I want doing, they will sit and talk and have a laugh." Another person told us, "I look forward to them coming. I just let them do what they have to do, nothing gives me cause for concern." A third person told us, "If I'm having a bath they come out, then I call out so they give me privacy." A relative we spoke with said, "I know that they communicate well as I listen all the time."

This focus on the individual also demonstrated that care staff had regard to people's dignity. One person told us, "This meant people felt secure when being supported with personal care by staff, who behaved in a compassionate way. A relative we spoke with said, "Yes she does get embarrassed, I tell her it's alright and the girls do too and they reassure her." People told us staff had helped to improve their quality of life. One person said, "Sometimes I am reluctant to get out of bed. They tell me it's a nice day, etcetera, and encourage me." A relative we spoke with said, "If [Name] wants to put something in the bin they get her to try, rather than them do it for her, so they do encourage her independence."

All people we spoke with were aware of the information in their welcome packs and felt able to play a part in the planning of their care. One person said, "Yes I have got a care plan in the house.

The registered manager and care co-ordinators were aware of the benefits of providing a continuity of care to people who used the service. People who used the service and their relatives agreed that, they could generally depend on a continuity of care from the same carers. One person told us, "I have a weekly planner and who is coming in an envelope in the post." Another person told us, "They usually bring the new one [staff] with the usual lady so I would know who is coming." Most people told us they knew the care staff who visited them and were told if it was going to be someone different.

We reviewed eight sets of care records and saw people had signed to say they agreed with their care packages. The people we spoke with were readily able to discuss what type of support they received and how they had gone through with staff exactly what their needs were and how these were best supported. Some people were able to tell us they had care reviews, one person said, "I think about every six months." A smaller group of people said they didn't have them or weren't bothered about them. We raised this with the

registered manager who stated they would make these review visits clearer with people so they understood their purpose.

We saw sensitive personal information was stored securely on IT systems and the entrance to the service's office was via a secure door. This meant people's sensitive information was treated confidentially.

We found the culture to be a genuinely caring one. One staff member told us, "I think showing genuine interest in people is the best way, engaging in rapport about their past for example is something most enjoy. All interactions should be friendly and genuine."

Good

Is the service responsive?

Our findings

Each person we spoke with and their relatives felt their needs were well met and that their preferences were acted on. One person told us, "I know about my care plan and of course I should have some involvement and I am encouraged to do this." Another person said, "I think there is a care plan in the house and yes my family and myself are included in all talks and changes." A third person also said, "My relative deals with anything to do with care plans because I would prefer not to." We saw this was recorded as such in the person's plan of care.

People who used the service and staff confirmed they took part in regular reviews. We saw evidence of the provider changing the support people received based on their needs, as well as liaising with external professionals to ensure people's changing needs were properly supported. We saw examples where staff had sought advice from district nurses regarding changes in medicines administration and occupational therapists regarding the using of moving and handling equipment. The provider also regularly liaised with GPs, social workers and the speech and language therapy (SALT) team. We found the relevant care plans and risk assessments had been updated accordingly.

Care files contained sufficient information for care workers to undertake the necessary tasks and had been improved in terms of person-centred content since the last inspection. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. We saw reviewed care plans had been re-written with the person's voice in mind and described the ways they wanted to receive care and not simply a list of tasks. For example, one person's care plan began with how they preferred to be addressed, whether they preferred a male or female carer and specifics about their personal care needs, such as, "I like to be left alone for five minutes and for the carers to leave the room, close the door and I will shout when I am ready." Another plan said, "If carers are unable to locate my glasses they may be under one of my pillows in the bedroom where I sleep."

We found these improvements to the documentation of person-centred care, to be consistent across the care planning we reviewed.

Staff we spoke with demonstrated a good understanding of people's likes, dislikes and individualities, as well as their care needs. People told us they were supported by staff who encouraged them. One person said, "I am always being encouraged to be more active and do things and it is working!"

The provider had a complaints policy in place, which was made available to people in their welcome pack. Everyone we spoke with was aware of how to make a complaint and confident they could do so if necessary. One person said, "I know how to complain and would if needed," and another said, "Yes I know to ring the office if I am not happy with anything."

A number of people cited instances of minor concerns they had, whereby the provider had resolved the problem. One person told us, "A girl [staff member] came; I couldn't get on with her. I told the office and they sorted it. She didn't do anything wrong, it was just a clash of personalities." On occasion we received

feedback from people who used the service that office staff were not responsive to their queries and that sometimes office staff did not call them back. There was however a consensus of opinion that, where issues were raised, they were resolved. We saw that this feedback from surveys had been incorporated into the service action plan and the registered manager was monitoring office staff responsiveness.

We found where complaints had been made they had been reviewed and responded to in line with the complaints policy, with the registered manager providing comprehensive responses and sharing any learning with the whole staff team via staff meetings. This demonstrated the provider ensured it used such complaints as an opportunity for learning.

The provider continued to use twice yearly surveys as a means of routinely gathering feedback from people who used the service and staff about how the service was performing. We saw the most recent survey results were largely positive.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. They had been registered with the Commission as the manager of the service since June 2016. They were suitably skilled, experienced and supported by the regional director. We found the registered manager to have a strong understanding of the policies and procedures of the service, as well as the ethos, as set out in the provider's statement of purpose.

At our last inspection in August 2016 we found that risk assessments did not reflect people's needs and people's risks had not been regularly reviewed. Staff had not always acted upon risks when they were identified. In addition, medicines were not managed safely, staff had not always recognised safeguarding concerns, there was a lack of understanding and application of the MCA, staff supervision and appraisals were not consistently carried out, staff training was not up to date and there were mixed views about staffing levels.

At this inspection we found that significant improvement had been made in all areas of concern at the last inspection and the service was now compliant with regulations.

Two people we spoke with told us, "I would say that now things are much better for the staff and for us as there seems to be more organisation," and, "Yes it is well managed. If I want to change something, I am able to." Relatives we spoke with said, "I speak very highly of Allied. [Name] was very unhappy when I was out [in the community]. I feel more relaxed now, I know she is being very well looked after. Another relative said, "As a family we have all benefited and the carers have enhanced all our lives."

Staff we spoke with felt the registered manager had taken to the role well, had made significant improvements, and was approachable. One staff member said, "She gets involved and makes sure the decision is right for the customer."

People who used the service provided positive feedback about the registered manager, and how the service was run generally. They told us, "The management say that they are always at the end of the phone to advise, guide and inform. I haven't needed to call yet, but have no reason to think that wouldn't happen now."

Healthcare and commissioning professionals described an established relationship with the registered manager, saying, "We have a good relationship," and, "They are proactive."

The registered manager had provided CQC with an action plan following the last inspection along with regular updates. At this visit we reviewed their progress against this plan and found they had delivered against it, with clear responsibilities and actions set out. This demonstrated the provider had successfully addressed the breaches of legislation since our last inspection. We also saw the provider had clear plans for the future of the service and used auditing and other qualitative information to inform these plans at a strategic level.

We found morale to be good with the majority of staff we spoke with. Staff confirmed they had been invited to team meetings and the new electronic rota system via mobile phones was working well. They said smarter rota planning for individual staff meant their daily runs worked around their home location so travel time was reduced and consistency for people using the service would increase. This system had only been operation for a number of weeks but the registered manager explained how it would be further developed when staff increased their confidence to include the person's full care plan being available on the mobile device. The registered manager also told us that this system would alert staff if their training went out of date and if they did not attend a minimum of four staff meetings a year.

The registered manager and co-ordinators were responsible for a range of audits to ensure errors were identified and practice improved, for example medicines audits, care file audits and competency assessments. Where significant concerns were identified about the practices of a member of care staff we saw the disciplinary policy was appropriately followed. Where there were more minor errors we saw these were addressed. Staff were encouraged to voice concerns and we saw following staff concerns about an element of the service delivery, the registered manager held a meeting where open and honest dialogue was held and staff we spoke with told us they felt confident they were listened to.

All staff we spoke with displayed a positive, caring attitude and it was clear in the responses from people we spoke with throughout the inspection that, whilst the provider still had improvements to make with regard to risk assessment, they had ensured the culture remained a caring one that was focussed on delivering good standards of care.