Westminster Homecare Limited

Westminster Homecare Limited (Chelmsford)

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Westminster Homecare Limited (Chelmsford) is a domiciliary care agency. It provides personal care to people living in their own home in the community, including older adults and people with disabilities. At the time of the inspection they were supporting approximately 150 people.

This announced inspection took place between 17 and 20 April 2018.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The service did not have a registered manager in place. However, a new manager had been recently appointed and were applying to CQC to become the registered manager. They worked closely with the operations support manager, who had until recently been the manager of the service.

At our last inspection in February 2017 we rated the service as requires improvement in all areas. We asked the provider to submit an action plan and monthly reports to show what they would do and by when to improve the service to at least a good rating. At this inspection, we found the provider and manager had taken action as required. However, whilst many areas of the service had improved to good, further time was needed to ensure the improvements were sustainable and so we continued to rate the service requires improvement overall.

The operations support manager had set up extremely good systems which were driving improvement and changing the culture of the service. Senior staff had good oversight of the support staff provided, and the service was better organised than at our last inspection. There were effective checks on the quality of the service with prompt action taken when concerns were found. Although we found some areas still needed improving, we had increased confidence that the systems were in place to continue to resolve concerns.

The provider had enabled senior staff to address the concerns we had found at our last inspection by reducing the pressure to meet targets and increase numbers of people using the service. However, the provider was responsible for the style of care plans staff used and had not ensured the plans presented information about people's needs and risks in a clear manner.

We found the service had not mitigated the risks to people's safety when they were discharged back to the community from hospital. The manager assured us they would address our concerns to improve communication with staff and ensure a more coordinated response to the risks around hospital discharges.

New systems had led to the increased safety of people at the service since our last inspection, such as the enhanced checks on the support people received with their medicines. Staff had been retrained in the administration of medicines and, whilst there continued to be some concerns in this area, the measures to drive improvement and safety were proving effective.

Risk assessments had improved, though information about how to minimise risk was not presented to care staff in a clear manner. Staff worked well as a team to support people who were at risk of abuse.

There were enough staff to meet people's needs. New people only joined the service when there was capacity within the staff team to support them safely. Rotas and visits were better coordinated so that people were supported in a more consistent and structured manner.

Staff had access to improved training and support. They were better skilled to meet the needs of people with complex needs, including people with dementia. People received support to access health and social care professionals where needed. 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, though there was scope to improve recording around how people's capacity was assessed.

Although we had concerns about the style of care plans, we found people were cared for by a more consistent staff team who knew them well. The support had become more personalised and less rushed than at our last visit to the service. People and staff told us they had more time to have a chat and meet people's needs in a less hurried way. Staff treated people with dignity and respect. A senior member of staff had been trained in supporting people at their end of life and ensuring people received coordinated care at this time.

People felt able to complain and were confident their concerns would be addressed. People and their families had varied opportunities to provide feedback about the service they received. Their views were taken into account and used to review the support staff provided to ensure it met their needs.

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 assessment had improved but guidance was not clearly presented. Risk was not always minimised when people were discharged from hospital.

Improvements in the administration of medicines were continuing.

The provider had safe recruitment practices and there were enough staff to meet people's needs. Visits were well coordinated and scheduled.

Staff worked together to protect people from abuse and understood how to escalate any concerns.

Is the service effective?

Good

The service was effective.

Staff had access to improved training and support, leading to enhanced skills.

Staff offered choice when providing care.

Staff helped people have enough to eat and drink

Staff support people to access health and social care services if required.

Is the service caring?

Good

The service was caring.

Staff had more time to develop relationships with people.

People received support from consistent staff who knew them well.

People were treated with dignity and respect.

Is the service responsive?

Good

The service was responsive.

People needs had been reviewed and care revised to ensure it met their needs in a person-centred way.

Specialist training had been arranged to ensure the service met the needs of people who required palliative care.

People's complaints were investigated and the information used to make improvements to the service they received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was no registered manager at the time of the inspection, though the manager had applied to be registered.

There was an improved culture at the service with better coordination and less focus on meeting targets.

There were effective measures in place to monitor the quality of the service. The systems in place were gradually addressing our concerns and driving improvements.

Westminster Homecare Limited (Chelmsford)

Detailed findings

Background to this inspection

Westminster Homecare Limited (Chelmsford) is a domiciliary care agency. It provides personal care to people living in their own home in the community, including older adults and people with disabilities. At the time of the inspection they were supporting approximately 150 people.

This announced inspection took place between 17 and 20 April 2018.

A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The service did not have a registered manager in place. However, a new manager had been recently appointed and were applying to CQC to become the registered manager. They worked closely with the operations support manager, who had until recently been the manager of the service.

At our last inspection in February 2017 we rated the service as requires improvement in all areas. We asked the provider to submit an action plan and monthly reports to show what they would do and by when to improve the service to at least a good rating. At this inspection, we found the provider and manager had taken action as required. However, whilst many areas of the service had improved to good, further time was needed to ensure the improvements were sustainable and so we continued to rate the service requires improvement overall.

The operations support manager had set up extremely good systems which were driving improvement and changing the culture of the service. Senior staff had good oversight of the support staff provided, and the service was better organised than at our last inspection. There were effective checks on the quality of the service with prompt action taken when concerns were found. Although we found some areas still needed improving, we had increased confidence that the systems were in place to continue to resolve concerns.

The provider had enabled senior staff to address the concerns we had found at our last inspection by reducing the pressure to meet targets and increase numbers of people using the service. However, the provider was responsible for the style of care plans staff used and had not ensured the plans presented information about people's needs and risks in a clear manner.

We found the service had not mitigated the risks to people's safety when they were discharged back to the community from hospital. The manager assured us they would continue to improve their response to the risks around hospital discharges.

New systems had led to the increased safety of people at the service since our last inspection, such as the enhanced checks on the support people received with their medicines. Staff had been retrained in the administration of medicines and, whilst there continued to be some concerns in this area, the measures to drive improvement and safety were proving effective.

Risk assessments had improved, though guidance about how to minimise risk was not always presented to care staff in a clear manner. Staff worked well as a team to support people who were at risk of abuse.

There were enough staff to meet people's needs. New people only joined the service when there was capacity within the staff team to support them safely. Rotas and visits were better coordinated so that people were supported in a more consistent and structured manner.

Staff had access to improved training and support. They were better skilled to meet the needs of people with complex needs, including people with dementia. People received support to access health and social care professionals where needed. 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, though there was scope to improve recording around how people's capacity was assessed.

Although we had concerns about the style of care plans, we found people were cared for by a more consistent staff team who knew them well. The support had become more personalised and less rushed than at our last visit to the service. People and staff told us they had more time to have a chat and meet people's needs in a less hurried way. Staff treated people with dignity and respect. A senior member of staff had been trained in supporting people at their end of life and ensuring people received coordinated care at this time.

People felt able to complain and were confident their concerns would be addressed. People and their families had varied opportunities to provide feedback about the service they received. Their views were taken into account and used to review the support staff provided to ensure it met their needs.

Requires Improvement

Is the service safe?

Our findings

At our previous inspection in February 2017, we found the provider and manager were in breach of regulations relating to the safety of people using the service. They had failed to adequately assess the risks to people's health and safety and had not consistently put in place measures to mitigate risk. They had also failed to ensure the proper and safe management of medicines. At the last inspection, we rated the service as requires improvement. At this inspection, we found safety at the service had improved and there was no longer a breach of regulation but there continued to be areas for improvement.

At our last inspection, we had concerns regarding the lack of guidance for staff when new people started using the service. This had now improved. Senior staff carried out pre-admission assessments before anyone new received care, and a temporary care plan was put in place before care staff visited. Where there had not been time for an assessment due to an emergency placement, senior staff carried out the first visit to ensure there was sufficient information in place. A member of staff told us, "There is better notice now if you are taking on a new client."

The service did not currently accept referrals from new people requiring discharge from hospital at weekends. This had reduced the risk of staff visiting people they did not know. However, we had concerns that in some instances care staff did not have sufficient information to support people returning home from hospital. The management team were aware of these concerns and told us mistakes usually happened because they had not received adequate discharge information from hospital staff.
We found examples of good coordination of hospital discharges, especially for people with more complex needs. However, improvements were required to ensure more consistency across the service. One person was discharged from hospital without catheter night bags or clear information about changes in their medicines. Shortly after discharge, their medicines run out. They also developed a pressure sore and required new equipment to ensure care staff carried out safe transfers. A second person had been discharged from hospital without their medicines. Staff had recorded on the medicine records the lack of medicines and raised concerns with office staff.
The manager showed us records where office staff had contacted district nurses and other health staff in response to the concerns raised. However, we found staff did not always have clear guidance to help minimise risk during hospital discharges, such as who was responsible for ordering medicines for an individual.
The management team and other staff told us that they were not taking on packages of care unless they were able to meet people's needs. They had reduced overall numbers of staff and had been through a period of consolidation. Senior staff had reviewed the rotas with all care staff, checking the tasks required, locations and time travel were realistic. Rotas had been changed, where necessary, for example to add extra travel time and most staff now had a set rota. This response demonstrated a commitment to ensuring people received safe and consistent support.

At our last inspection, we found the manager and provider had failed to pick up a large number of missed visits. At this inspection, we found there was a marked improvement in the deployment and scheduling of staff, with a subsequent reduction in missed visits. People gave positive feedback about the improvements

in the timings of visits. They said, "There's always the odd emergency so they can't help being late, but they come mostly at the same time" and "They come four times a day, and they always come, a call has never been missed at all." Missed visits were investigated thoroughly, logged and action taken to minimise the risk of re-occurrence. Senior staff now knew where staff were and so they could effectively monitor whether people were receiving safe care.

There were clear systems in place for supporting staff out of hours and logging any concerns. The management team had clear oversight of any issues and ensured actions were taken as required.

At our last inspection, we found staff did not have sufficient guidance about people's needs. Senior staff had reviewed care plans which now provided improved guidance to staff. However, we noted care plans were extremely long and it was not always easy to find some key information. The individual branch manager was not able to amend the care plan form as this was led by the provider. We found the local management team were aware of our concerns and were committed to resolving the issue.

Each person had a summary of the main risks care staff needed to be aware of when supporting them, highlighting risks, from dementia or from the medicines they took. Fire and environmental risk assessments had improved and we saw staff had referred a person to the fire service due to concerns about their safety in the event of a fire. There were adequate measures in place to minimise the risk of infection. Staff had attended infection control and food hygiene training. A family member told us, "They always wear their gloves and aprons and they're good at cleaning up afterwards too."

Guidance on the use of equipment to help people's transfer had improved since our last inspection. However, additional improvements were needed in this area, which we discussed with senior staff. For example, guidance did not always highlight exactly which loops staff needed to use on a hoist. Guidance on support with catheters had improved, though care plans did not always state who was responsible for the weekly catheter change. This information was especially important when people were being supported by new or replacement staff.

At our last inspection, we were concerned staff did not always have sufficient guidance regarding the support people needed to take their medicines safely. Guidance in care plans had now improved. For example, staff were instructed to observe a person with dementia to ensure they had taken their tablets. Staff knew which people's medicines needed to be taken at a set time, for example, a person who was on time critical medicine for Parkinson's had set visit times. Our observations of staff showed us staff were more aware of the importance of people receiving safe support with their medicines.

There were new systems in place to drive improvements in the administration of medicines, for example senior staff now regularly checked for any changes in prescriptions to ensure care plans were accurate. The operational support manager told us they carried out a high level of audits as they recognised the need to improve recording of this area. Our findings confirmed there continued to be a need for improvement, for example, staff had failed to sign they had supported a person with their medicines 13 times over a two-week period. Senior staff told us further investigations into all these errors had shown staff had administered the medication but not recorded their actions. This lack of recording meant senior staff and other health professionals were unable to monitor what medicines a person had taken.

We were reassured by the robust systems in place and by the commitment of senior staff to improve the safety in the administration of medicines. Where a member of staff repeatedly made mistakes in the administration of medicines, they received intense tailored training and, where necessary, disciplinary measures were taken. We saw staff received advice about medicines regularly, for example in team meetings

and in the staff newsletter.

During one of the home visits a member of staff highlighted to us where there had been several mistakes in recording the administration of creams. We were impressed by their openness and by the time we had returned to the office, office staff had already addressed the error.

There was an improved business continuity plan in place for use in the event of an emergency. As part of this staff had reviewed the risks for each person, for example, whether a person required support with time critical medicines. The plan had worked well during the heavy snowfall early in 2018. People told us they were impressed about how committed and organised staff were in ensuring they continued to provide essential support to people during this time. This response was aided by the improvements in rotas, as staff were largely working manageable and local routes.

There were improved systems in place for raising concerns when people were at risk of abuse. Staff had received training in safeguarding. Prior to our inspection we had noted good practice by staff who raised concerns to help protect people. We saw detailed investigations took place as a result. Senior staff logged where there had been alerts regarding people's safety and tracked the alerts to ensure concerns had been fully investigated.

Safe recruitment practices were followed to check staff were of good character and suitable for the roles they performed. The provider had the necessary pre-employment and identity checks in place before staff could commence work. These systems were well ordered and effective.

Good

Is the service effective?

Our findings

At our previous inspection, in February 2017, we rated the service as requires improvement because staff did not always have the skills to support people with specific health and social care needs. At this inspection, we found the service had made improvements in this area and was now rated as good.

People and their families told us staff consistently had the skills to meet their needs and gave us positive feedback about the support they received. A family member said, "My relative is getting the right service. I don't know if it could be better - they just do what's written. They know what to do. They sort it out."

There was now a standardised training programme across the regional teams and new training for staff was in place. A member of staff told us, "There is a new way of training. The new trainer is fantastic and brings so much more knowledge and helps us link it to people's needs." Office staff tracked the training staff received to ensure there were no gaps. We had positive feedback about staff's skills. Family members told us, "[Person] can't stand so two staff use the hoist and they do it properly" and "[Person] uses a frame, and the carers help by encouraging them to walk a bit in the mornings and are really good."

A member of staff told us they had completed an in-depth induction programme over five days and had not started providing support until all necessary checks and training were completed. They said much of the induction was practical, such as the manual handling training. New staff shadowed more experienced staff before going out to support people. A person told us, "New carers come with a usual carer, and they say, 'She's training'."

Staff told us senior staff supported them well through supervision and team meetings. There were effective systems to track the support staff received. Although we had some negative feedback about communication from office staff, this had improved greatly since our last visit.

In the past, we had concerns staff did not have the skills to support to people with dementia. Care in this area had improved. A family member said, "My relative has got vascular dementia. I think staff make sure [relative] talks to them and practices their memory." A member of staff told us they felt better equipped supporting people with dementia because of improved training and care planning. They gave us an example where they had removed a patterned tablecloth for a person with dementia who was struggling to eat, which had improved their concentration at meal times. When we visited a person's home, we observed a member of staff encouraging them to eat an orange, despite initial reluctance. The staff showed a good level of skill and commitment in their role.

Staff supported people to eat and drink as required. We noted visit times had increased for a person to ensure members of staff observed them eating. A family member told us, "The carers check [person's] fluids and make sure they are drinking plenty." Staff completed food and fluid charts when people were at risk of malnutrition and dehydration and senior staff reviewed the charts to monitor people's wellbeing.

Despite the concerns we raised in the safe section of this report around hospital discharges, we found good

evidence of staff working with and making referrals to other health and social care professionals. Staff had highlighted when equipment was not working and communicated well with office staff who arranged for a referral to occupational therapy. Other people had been referred to district nurses or GPs when staff had concerns about their health. A health professional told us staff worked well with them to support a person and followed the advice they had given.

Care plans had improved guidance about people's health care needs, for example, a person's care plan had information about their diabetes and staff were given information leaflets about the condition. There was room for improvement in this area, in line with best practice, for example the person did not have a specialist risk assessment providing detailed guidance around how diabetes affected them personally.

We checked whether the service was meeting its responsibilities under The Mental Capacity Act 2005 (MCA). The 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. At the time of our inspection, we found that the provider was working within the principles of the MCA where necessary and appropriate to the needs of the people they supported.

Guidance on supporting people to make a choice was threaded through care plans. For example, a person's plan stated they could communicate vocally about their choice of clothes, despite lacking capacity in other areas. When we spoke with staff, we noted they understood and respected people's ability to make choices. There was room for improvement in the information provided in care plans around people's capacity. In particular, there was limited information on what assessments had taken in place regarding a person's capacity and how this had been assessed and reviewed. An officer from the local authority told us they had asked the service to improve their records around MCA. We could see in the care plans that the service had started to address this, though this task was still being completed.

Good

Is the service caring?

Our findings

At our previous inspection, in February 2017, we rated the service as requires improvement because people told us they were anxious when their usual carer was not there. At this inspection, we found the service had made improvements in this area and was now rated as good.

People told us their needs and preferences continued to be met when temporary care staff provided support. A person described how all staff knew how to support them, "The carers are very aware now, even the weekend carer, there are no problems, they are amazingly well trained." People also told us, "We have the same person five days a week, the weekends vary but they're still good and they seem trained" and, "I have a different carer on a Sunday and they are good enough."

We found senior staff and the management team had enabled staff, through improved and consistent rotas, to develop positive relationships with people. One person said, "The carers are familiar. I always get the ones I know." A family member said, "My relative has a laugh and a chat with them, it's a friendly atmosphere. We know each other because it's mostly the same staff."

The improved rotas meant staff were less rushed. A relative told us, "[Person] is not rushed, they're quite good and say, 'take your time'. They're usually here for the right length of time." There was some negative feedback from people about staff turnover and the number of new faces. Despite this feedback, we found changes in care staff were introduced in a sensitive way. A person told us, "I do get new carers and usually they bring someone to introduce them."

Improved information in care plans meant staff were better informed about people's needs and interests. Care plans documented people's wishes and were written in a way that put the person at the centre of their care, for example a person's plan said, "Staff will begin by putting in my hearing aids before any care is provided."
We saw that people's views about their care were ascertained as part of telephone monitoring and spot checks and used to revise their care plans and support, for example to change the times of visits. Staff encouraged people to remain independent and care plans clearly outlined which tasks people people could carry out on their own. For example, one person's care plan stated staff should fill a sink of warm water but that the person was able to do a strip wash with supervision.

During our visits to people's homes we observed staff knew people well. A member of staff offered to put on a person's favourite TV programme as we left. Another member of staff told us of their pride when they had, through trial and error, finally found out the best way to support a person. People told us, "I feel lucky to have them, they're more like friends to me" and "I'm friends with all of them. I have a good laugh with all my carers. I have no complaint."

Many people and families told us they felt the service's response during the heavy snow, early in 2018 was very caring. People told us, "They always come, even in the snow" and "They still got here. They made a flask of tea and made sure I had enough to eat and drink in case they had to miss a visit." Our discussions with the

management team highlighted that the pro-active preparations and coordination from office staff enabled and promoted this caring response in challenging circumstances.

Care plans documented people's preferences to promote their privacy and dignity. One care plan stated, "Once I am ready to come out of the shower I will call for my carers, who will place a towel around my top half." There were prompts for staff in care plans to ensure curtains were closed during personal care. A member of staff told us how they promoted a person's dignity. They said, "I say to them, 'why don't I make you a cup of tea whilst you are on the commode'."

Good

Is the service responsive?

Our findings

At our previous inspection, in February 2017, we rated the service as requires improvement in responsive. Staff did not have enough information to meet people's needs and preferences and, as a result, people did not consistently receive person centred support. At this inspection, we found improvements and there was no longer a breach of regulation. The service was now rated as good.

Since our last inspection, senior staff had reviewed and revised care plans to provide more person-centred guidance about people's needs. The provider required the service to use a standard care plan format. The resulting care plans contained a lot of information but were lengthy and not presented in an accessible format. Many peoples care plans were over 40 pages long. Staff acknowledged they did not have enough time to read the whole of the care plans before providing care. To mitigate this, senior staff tried to capture key information, such as risks around falls and allergies, within a few sections of the care plan. There was also information on people's social history and preferences, for instance their favourite TV programmes.

We reviewed the comments by staff and the feedback from people and families. We found that despite the cumbersome care plans, staff were providing support which was personalised. We raised our concerns regarding the style of care plan with the area manager and they agreed to raise this with the provider, as discussed in the well led section of this report.

The marked improvement to the scheduling of visits meant people were supported by a consistent staff team and so received a more personalised service. Staff communicated and worked well as a team to meet people's needs. We received feedback that staff provided flexible support. One relative said, "To be honest sometimes we keep them longer but they don't mind." A person told us, "They always ask if there's anything else and if I tell them something they do it, like getting the clothes out of the washing machine, drying the clothes, hanging them up. I'm very, very happy with them."

We received feedback that gender preferences were generally followed but this was not always the case. A person told us, "I prefer female carers. I've told them this before but I feel I don't get a choice, at the moment it's 80% female and 20% male." We discussed this with the manager who advised they explained to people when they set up the care plan that they would try and honour preferences for a male or female care staff but that this could not be guaranteed.

A senior staff member coordinated the reviewing of peoples' needs which worked better than when we last inspected. People's care plans were reviewed at least annually and senior staff also carried out home visits and telephone reviews to ensure they were satisfied with the service they were receiving. The process ensured support was more person centred and responsive to individual needs. For example, a person had used the on-going review process to trial new times for visits. Staff also triggered reviews by raising concerns. For instance, a review was arranged to look into concerns when staff were struggling to turn a person in bed.

People and their families felt able to ring to complain and were confident their concerns would be

addressed. One family member said, "Occasionally I ring with concerns but [relative] is happy so I don't do that much. They do sort out what I ask." The management team investigated complaints thoroughly and used information gained to drive improvements. For example, senior staff had challenged a member of staff after a complaint from a person that they did not receive a bath, as planned. Another person had complained that the timings of visits on a Sunday meant they could not get to their place of worship. This had been resolved to the person's satisfaction. All complaints were logged to ensure they were resolved and to capture any themes.

Support to people at their end of life had improved. One of the senior staff was the end of life champion and had attended specialist training. We were told they were visiting a person with palliative needs shortly after their discharge from hospital to ensure the care package met their needs. Care plans did not have a specific end of life section to people's preferences and choices for their end of life care. We discussed how this could be improved with senior staff.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection, in February 2017, we rated the service as requires improvement. We found the provider and manager were in breach of regulations relating to the management of the service as they had failed to fully resolve the concerns we had raised at our inspection in 2016. Risk was not minimised and the service provided did not consistently meet people's needs and preferences.

At this inspection, there was no longer a breach of regulation, however the service continued to be rated as requires improvement. After our last inspection we had asked the provider to send us a monthly report, to ensure they were addressing our concerns. This report had been sent in punctually and demonstrated an understanding of the challenges at the service and a clear set of actions to drive improvements. More time was needed to ensure the improvements were sustainable, however we found, the service had taken the necessary actions to address our concerns and was travelling in the right direction.

The last registered manager had left since our inspection in 2017. A new manager had been appointed who had driven many of the improvements at the service. They had recently been promoted to operations support manager, and a new manager promoted from within the service, who had applied to become the registered manager. The operations support manager remained highly involved in the running of the service and was mentoring the new manager. As a result, we found there was minimal disruption from these changes.

The managers and other senior staff at the service had tackled the challenges at the service with commitment and integrity. There had been a shift in culture, for example the management team set an expectation with staff that missed visits were no longer the norm. Many care staff had left and new staff had been appointed who were committed to the improvements at the service.

Some relatives told us communication from the office was still an issue but feedback from families and people using the service was largely positive. A relative told us, "We have newer carers at the moment as some have left, but the new girls are amazing and bend over backwards to help my [relative]." Another family member said, "Basically I know who is the manager is as I've had to deal with them, and I would talk to them again, it wouldn't be a problem. It's all working for me okay. I'm satisfied."

At our last inspection there had been a focus on meeting targets for new clients, at the expense of safety and quality of care. At this inspection, we found the manager had worked with the provider to reduce this pressure. The operations support manager told us, "We get offered a high number of packages a day but only take what we can manage."

The operational support manager was excellent at setting up effective systems and we were assured that they would continue to improve processes around hospital discharges. We also discussed our concerns regarding the care plan format and found this was outside of the remit of branch managers as care plans were standardised across the wider organisation.

We looked at findings from recent inspections carried out in other branches. Whilst all the reports stated the care plans held a great deal of information, some previous inspections had highlighted that the care plans were inaccessible and cumbersome. The manager showed us some recent improvements to the care plan template, however we found the provider had not developed care plans which were easy to read, in line with best practice. This increased pressure on staff and increased the risk of them missing key information. Our discussions with staff confirmed this.

Despite staff's comments about care plans, their general feedback was much more positive than at our last inspection. Staff told us, "We definitely had problems last year, but now its 100% better. You can ring the office about anything. I am much happier" and "The manager tells us we have done a good job." Some staff were still unhappy about communication with the office and the scheduling of visits, however these comments had reduced since the last inspection and we could see there were measures in place to address these concerns.

A member of staff said, "The communication between the office and the carers has improved by 100%." We also heard from two members of staff that communication was still an issue between office and care staff. The management team told us they were aware of this feedback already and were working to improve communication. There were monthly staff meetings and important information was communicated by phone and then on the weekly rota, for example if new equipment had arrived.
There were well defined roles in the service. A staff member told us, "I know who my coordinator is and we have a good working relationship. They know the people I support and the situations they are in." When we had questions during our inspection, staff knew who we had to speak to for answers.

The checks on the quality of the service had improved significantly. There were clear systems to resolve any issues or errors uncovered from the checks. The responsibility for quality checks were varied and delegated well among senior staff and managers. This included telephone monitoring and home visits, which were used to gather information about the service and to review the support provided to ensure people's need were met. Some senior staff went out on care visits which meant they kept up to date with the realities of care for staff and people.

Senior staff checked all medicine administration records for gaps and we saw they addressed poor practice effectively. The manager told us they had decided every medicine record should be audited due to the number of recording errors. The sheer size of the task meant a delay in the process, and some of the concerns we had found had not yet been picked up and addressed. However, this attention to detail demonstrated the high level of commitment which was gradually turning the service round in a consistent and sustainable manner.