Here to Care Limited

Here2Care (Dartford)

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

Overall summary

The inspection was announced and was carried out on 12 and 13 March 2015 by two inspectors and supported by two experts by experience.

Here2Care (Dartford) is a domiciliary care agency providing personal care to people in their own homes in and around Rochester Kent. The service provides support for people in their own homes in the Dartford and Gravesham areas. The people using the service are older people, people living with dementia, physical and learning disabilities or mental health difficulties.

At the last inspection on 06 May 2014, we asked the provider to take action to make improvements to people's care plans; the management and recording of the administration of medicines; and the monitoring system to assess the quality of service people received. We received an action plan stating that all remedial action would be completed by 07 November 2014. During this inspection we found that this action had been completed.

Summary of findings

There was a registered manager in post. 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.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to report any concerns.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how risks of re-occurrence could be reduced.

There were enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were calculated according to people's changing needs. The manager followed safe recruitment practices.

Staff were trained in the safe administration of medicines. Records relevant to the administration of medicines were monitored to ensure they were accurately kept and medicines were administered safely to people according to their needs.

Staff knew each person well and understood how to meet their support needs. Each person's needs and personal preferences had been assessed before care was provided and were continually reviewed. This ensured that the staff could provide care in a way that met people's particular needs and wishes.

Staff had completed the training they needed to care for people in a safe way. They had the opportunity to receive further training specific to the needs of the people they supported. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal.

All care staff and management were trained in the principles of the Mental Capacity Act 2005 (MCA) and were knowledgeable about the requirements of the legislation. People's mental capacity was assessed and meetings were held in their best interest when appropriate.

Staff sought and obtained people's consent before they provided care. When people declined, their wishes were respected and staff reported this to the manager so that people's refusals were recorded and monitored.

Staff provided meals when this was part of the support needed and ensured meals were well balanced to promote people's health. Staff knew about and provided for people's dietary preferences and restrictions.

People told us that staff communicated effectively with them, responded to their needs promptly and treated them with kindness and respect. People were satisfied with how their care and treatment was delivered.

Clear information about the service, the management, the facilities, and how to complain was provided to people. Information was available in a format that met people's needs when they had visual impairment.

People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity.

People were referred to health care professionals when needed and in a timely way. Personal records included people's individual plans of care, likes and dislikes and preferred activities. They encouraged people to do as much as possible for themselves.

People's individual assessments and care plans were reviewed regularly with their participation or their representatives' involvement. People's care plans were updated when their needs changed to make sure they received the care and support they needed. A person told us, "A care advisor comes out and goes through the care plan with us, it is very detailed and I am very happy with this. She makes any changes that are necessary".

The provider took account of people's complaints, comments and suggestions. People's views were sought and acted upon. The provider sent questionnaires regularly to people, their legal representatives and stakeholders. The results were analysed and action was taken in response to people's views.

Staff told us they felt valued and supported under the manager's leadership. There was honesty and transparency from staff and management when mistakes occurred. The manager notified the Care Quality Commission of any significant events that affected

Summary of findings

people or the service. Comprehensive quality assurance audits were carried out to identify how the service could improve and the manager had an action plan for making the improvements.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Staff were trained in the safeguarding of vulnerable adults and were knowledgeable about recognising the signs of abuse. Staff knew about and used policies and guidance to minimise the risks associated with people's care.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to safely meet people's needs.

Thorough staff recruitment procedures were followed in practice. Medicines were administered safely.

Is the service effective?

Good

The service was effective.

All staff had completed essential training to maintain their knowledge and skills. Additional training was provided so staff were knowledgeable about people's individual requirements.

The provider was meeting the requirements of the Mental Capacity Act 2005.

People were supported to be able to eat and drink sufficient amounts to meet their needs. People were provided with a choice of suitable and nutritious food and drink.

People were referred to healthcare professionals promptly when necessary.

Is the service caring?

Good

The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.

Information was provided to people about the service and how to complain. People were involved in the planning of their care and support and staff provided clear explanations to support people's decisions.

Staff respected people's privacy and dignity.

The staff promoted people's independence and encouraged people to do as much for themselves as possible.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they moved into the service. People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated when people's needs changed.

People knew how to complain and people's views were listened to and acted on.

Summary of findings

Is the service well-led?

Good

The service was well led.

There was an open and positive culture which focussed on people. The manager sought people and staff's feedback and welcomed their suggestions for improvement.

Staff had confidence in the manager's response when they had any concerns.

There was a system of quality assurance in place. The manager and senior staff carried out audits of every aspect of the service to identify where improvements to the service could be made.

Here2Care (Dartford)

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 was carried out on 12 and 13 March 2015 and was an announced inspection. Notice of the inspection was given because we needed to be sure that the managers and staff we needed to speak to were available.

The inspection was carried out by two inspectors. Two experts by experience supported the inspection by contacting a number of people who received care from the agency to gather their feedback. 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 experts by experience's area of expertise included caring for older people, people with dementia and with mental health difficulties. 221 people received care from the agency at the time of our inspection. We accompanied care workers while they visited two people's homes to observe standards of practice, with people's consent.

Before our inspection we looked at records that were sent to us by the registered manager or social services to inform us of any significant changes and events. We reviewed our previous inspection reports and the service's improvement plan. We consulted an occupational therapist and a district nurse who regularly visited people who received care from the service. We obtained their feedback about their experience of the service.

We spoke with 28 people and 9 of their relatives to gather their feedback. We also spoke with the registered manager, a director who had the responsibility for supervising the management of the regulated activity, a senior care coordinator, the assistant deputy manager, five members of office staff and eight members of care staff.

We looked at records that included twelve people's care plans and reviews, risk assessments and medicines administration records. We consulted six staff files, staff rotas, staff training records, satisfaction surveys, quality assurance checks, audits and sampled ten policies and procedures.

Is the service safe?

Our findings

People told us that they felt safe when staff provided care and support. People told us, "I feel very safe with my regular carers, they make me feel comfortable", "I like the way they (staff) work, and they make me feel safe". A relative told us, "The staff are marvellous, they coped with an emergency for my Mum extremely well and they showed they knew exactly what to do, it is good to know we can rely on them for quick action".

At the last inspection on 6 May 2014 we found that people's care plans did not contain sufficient guidance for staff to follow; people were not protected against the risks associated with medicines because the provider did not have appropriate arrangements in place to manage and monitor the administration of medicines. Appropriate action had been taken to remedy this and ensured the provider achieved compliance with the Regulation 9 of the Health and Social Care Act 2008.

A new system of recording and managing the administration of medicines had been implemented to ensure people received their medicines safely. The service held a policy for the administration of medicines that was regularly reviewed and current. Staff had received appropriate training and competence checks in the recording, handling, safe keeping, administration and disposal of medicines. People's needs relevant to their medicines were assessed at three levels which determined the staff that were allocated to support them according to the staff's skills and knowledge. One level support was provided for people who self-medicated and who may need prompting. At another level staff assisted or administered the medicines. At a further level, staff who had received specialist training administered medicines for people who were unable to take medicines orally. People had a 'medication plan of care' that included clear guidance for staff to follow. This included how and when to administer medicines that were prescribed to be taken 'as required'.

Staff signed individual Medication Administration Records (MAR) to evidence the medicine had been taken. Appropriate coding was used to indicate when people refused, were absent or too ill to take their medicines. MAR sheets were returned to the office every four weeks and were audited by the manager to check that they were accurately completed.

There were sufficient staff on duty to meet people's needs. There were 95 care workers for 221 people, averaging 1713 hours a week. Some people told us, "I never know who I am going to get at the weekend, it is not like the service during the week" and, "The weekend is pot luck as I may get a worker I do not know". A member of staff told us, "During the week there is definitely enough staff, but at weekend we often get called in to cover other people and because we are not prepared to rush them we often run late". We discussed this with the registered manager, the care co-ordinator and the human resources manager. They confirmed that there were difficulties in covering shifts at weekend when staff were absent. However, all calls were appropriately covered at weekends. The manager told us, "Weekend cover is always difficult as staff are often absent at short notice and we are continuously and actively recruiting so that people will have more continuity of staff. In the interim we often have to send workers who may not be familiar faces at weekend to make sure care continues to be provided".

There was an out of hours and weekend team whose sole task was to ensure weekend calls were provided with as little delay as possible. Several members of staff had been employed specifically to remain on standby and were asked to step in when shortfalls of staff at weekend were identified. The provider had started to recruit care workers who lived locally and could walk to people's homes. The human resources manager told us, "We are advertising for additional staff continuously". A new system of 'double run' had been implemented, when two care workers went to provide care to people together instead of waiting for the other one to arrive. Travelling time was taken into account when staff's visits were scheduled. A care worker told us, "Sometimes it is tight depending on the traffic but on the whole we have enough time to get there, or we let the office know and they contact people".

The manager and the care advisor reviewed the care needs for people whenever their needs changed to determine the staffing levels needed and increased staffing levels accordingly. People told us that when they needed two care workers this was provided. This ensured there were enough staff to meet people's needs.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. Staff had made appropriate referrals to the local authorities when they had been concerned about people's

Is the service safe?

safety. Staff training records confirmed that their training in the safeguarding of adults was annual and up to date. Additional training for safeguarding children was also provided. The registered manager told us, "We have included this training as although we do not provide care for children, they may be present at times". The members of staff we spoke with demonstrated their knowledge of the procedures to follow to report abuse and they knew how to use the whistle blowing policy should they have any concerns. One member of staff said, "I have no problem raising a concern; for me, if you don't raise it you are not caring". Another care worker said, "Part of my role is to protect people". They told us that they had confidence in the manager's response. They said, "The manager is great, she will support us if we raise any concern and will see it through to make sure people are safe".

We checked six staff files to ensure safe recruitment procedures were followed. Recruitment procedures included interview records, checking employment references and carrying out Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with vulnerable people. Gaps in employment history were explained. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. They were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce the risks and appropriate guidance for staff. For example, a person had been identified at being at risk of falling. The risk assessment contained instructions for staff to ensure the person had a walking stick at hand at all times. Another risk assessment for a person who had risk associated with diabetes recommended the staff to provide an appropriate diet and ensure that visits were provided at regular periods to ensure their wellbeing. An environmental risk assessment had identified a risk of electrocution for people and staff and had recommended specific precautions to be taken while repairs were being carried out. The recommendations were implemented and recorded by staff at each visit.

Assessments of people's environment were carried out in their homes before the service started to provide care. These included checking the access and exit of properties, and identifying potential hazards such as stairs, floorings and kitchen appliances. People were referred to fire service if they wished to have a fire detector device installed. People were referred to appropriate services when they wished to have a safe keeping system for their keys. All equipment that assisted people in their home was checked each time people's care was reviewed. This included checking that hoists were in good working order, serviced regularly and that the correct size of slings was used.

There was a system in place for managing accidents and incidents. These were recorded and monitored daily by the manager. If people had experienced a fall, their environment and care package were re-assessed to ensure hazards were identified and reduced.

The registered manager ensured that the office premises were secure. Access to the premises was secured with an alarm system. Fire drills were practised twice yearly and all fire protection equipment was regularly serviced and maintained. Evacuation plans were clearly displayed in the office. All staff were trained in first aid and fire awareness.

The provider had an appropriate business contingency plan that addressed possible emergencies such as extreme weather and epidemics. This plan was specific to the service and included current details of people's individual needs in case of evacuation. When people have expressed their wishes regarding resuscitation, staff were made aware of where to locate the relevant document in people's homes in case of emergency.

Is the service effective?

Our findings

People's needs were assessed, recorded and communicated to staff effectively. The staff followed specific instructions to meet individual needs. Two people told us, "The staff know exactly what to do and how to do it" and, "My care worker is an excellent example of care, she really goes the extra mile and shows me new methods of coping with everyday tasks" and, "They help me do what I want to do and do not take over".

Staff had appropriate training and experience to support people with their individual needs. Staff confirmed they had received a comprehensive induction and had demonstrated their competence before they had been allowed to work on their own. Records showed that all essential training was provided annually, was current and that staff had the opportunity to receive further training specific to the needs of the people they supported. This included dementia care and diabetes awareness, catheter and stoma care, palliative care, dignity and equality, learning disability and managing behaviours that challenge. A care worker had requested additional training as they provided support for a person with epilepsy. This training was scheduled to take place. A member of staff who had omitted to administer a medicine was being re-trained. A member of staff told us, "All the training is 'face to face', sometimes even on a one to one or in small groups with the trainer so we can discuss how the training translates into what we do; this is so much more effective than sitting in front of a computer". Staff were subject to disciplinary procedures if they did not attend their training or refresher courses.

The staff knew how to communicate with people. They used specific methods of communication when appropriate. For example, they drew pictures of what they meant, or pointed to explain themselves and be understood by a person who used a foreign language. These methods had been agreed with the person when their needs had been assessed and a family member was used as an interpreter. A relative told us, "I am amazed at how they manager to have quite long conversations with my mother as it is normally quite difficult to chat with her". The staff we spoke with were knowledgeable of the specific needs of people who lived with dementia. A member of staff told us, "It is important to see things from their perspective, not upset their routine, be clear with our explanations and reassure them if they are anxious".

All members of care staff received one to one supervision sessions every three months and were scheduled for an annual appraisal. They were able to receive additional one to one support sessions upon request. Staff were supported to gain qualifications in health and social care. One member of staff told us, "We are strongly encouraged to enrol, do the studies and qualify so we can progress". Staff had been promoted to higher positions within the service. A member of staff had their rota altered at their request, to accommodate childcare. As this support was provided, staff were enabled to carry their role effectively.

Staff and management were trained in the principles of the Mental Capacity Act (MCA) 2005. We discussed the requirements of the MCA with the registered manager and they demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. A system was in place to assess people's mental capacity for decisions, for example whether or not to accept assistance with personal care or the administration of medicines. Such assessments were followed by best interest meetings to make decisions on people's behalf when appropriate.

Staff sought and obtained people's consent before they helped them. People told us, "They ask me what I want to do"; "They always make sure all they do is OK with me before they do it". People's refusals were recorded, respected, and monitored by the manager. Staff checked with people whether they had changed their mind and respected their wishes.

When staff prepared meals for people, they consulted people's care plans and were aware of people's allergies, preferences and likes and dislikes. People were involved in decisions about

what to eat and drink as staff offered options. The people we spoke with confirmed that staff ensured they had sufficient amount to eat and drink and promoted a healthy diet. Staff ensured the food was well presented to promote people's appetite. One person said, "When they put the food on my plate- it's art! It looks good, as well as tastes good".

Is the service effective?

People were involved in the regular monitoring of their health. When staff had concerns about people's health this was reported to the office, documented and acted upon. People were referred to a G.P. or a district nurse when there were concerns about their health and medical needs. A district nurse who visited people who received care from the service told us, "The care workers are very good at following instructions when people are at risk with their skin and they keep me informed if there are any changes I need to be aware of". An occupational therapist who provided equipment for people said, "They called me when in doubt about how to use a particular piece of equipment and they followed the guidance well". A person whose appetite had declined had been referred to their G.P. and a dietician. Another person who needed additional equipment in their home to help them move around had been referred to an occupational therapist. This ensured the delivery of people's care and support responded to their health needs and wishes.

Is the service caring?

Our findings

All the people we spoke with told us they were satisfied with the way staff supported them. They told us that the staff were "very good" and that they often did more than they should. They said, "They always finish their tasks and do not rush simply because the time is up", "All do that little extra when needed", "Their name is just right: they are here to care". Other comments included, "They are very good; couldn't be better; I can't fault them", "The staff are truly marvellous", "The staff are cheerful, friendly and pleasant", They are lovely girls" and, "They are kind and polite, respectful and dedicated".

Positive caring relationships were developed with people. Staff told us they valued the people they visited and spent time talking with them while they provided care and support. Two members of staff said, "We are bound to develop a good relationship with people and become part of their lives in some respect and this is how it should be" and, "I like to think that I make a difference and that people look forward to seeing me each day". Two people told us "I have had the same care worker for the past three years; she is just like one of the family" and, "Talking to these girls [staff] is better than all the tablets in the world".

Staff were made aware of people's likes and dislikes to ensure the support they provided was informed by each person's preferences. A person's care plan included the fact that they wished to have a full English breakfast and this was provided. Staff took account of people's cultural diversity. A person had requested the staff followed a particular ritual when helping them with bathing due to their religious requirements and this was carried out.

Information was provided to people about the services available, the cost and how to complain. A leaflet, a brochure and a service user guide were available in a larger format to assist people with visual impairment. Surveys included a pictorial format to help people express their levels of satisfaction. Explanations were provided by staff to people appropriately. A care advisor visited people in their homes before support was provided. This ensured people were involved in planning their care and support and that they were provided with explanations. One relative told us, "We all sat together and we were able to get all our questions answered".

The service held information about advocacy services and followed guidance that was provided by the local authority. A system for referring people to advocates when necessary was in place. Advocates can help people express their views and wishes when there is no one else to speak on their behalf.

People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity. The staff had received training in respecting people's privacy, dignity and confidentiality. One person told us, "The staff take account of my modesty and treat me with great respect". The service held policies on dignity and respect, confidentiality, social media and networking that had been updated in January 2015. Staff were reminded of the importance of protecting people's information at team meetings.

The staff promoted people's independence and encouraged people to do as much as possible for themselves. Some people received support when they attended a day centre, went to a hydro pool, shopped, and did their laundry. A person's care plan instructed the staff to enable a person to enter a car unaided as they preferred to do this without support. A person said, "They help me do what I want to do and do not take over". A care worker told us, "I assess and encourage them to do what they can- I don't want them to give up".

Is the service responsive?

Our findings

People received care that was responsive to their individual needs. People told us, “They come every three months and check the plan for my needs. As I get older things change so it gets changed too” and, “A care advisor comes out and goes through the care plan with us, it is very detailed and I am very happy with this. She makes any changes that are necessary”. A relative told us, “They are good at understanding when changes need to be made like when more care is needed”.

At the last inspection on 06 May 2014 we found that people’s care plans did not contain sufficient guidance for staff to follow. Appropriate action had been taken to remedy this and ensured the provider achieved compliance with the Regulation 9 of the Health and Social Care Act 2008.

A care advisor carried out people’s needs and risk assessments before the care began. This included needs relevant to their mobility, health, communication, likes and dislikes and social activities. The staff were made aware of these assessments to ensure they were knowledgeable about people’s particular needs before they provided care and support. Within three days, these assessments were developed into individualised care plans that were re-submitted to people for them to make amendments if they wished. The care plans were comprehensive and reflected every aspect of people’s care.

People’s care was planned taking account of their preferences and what was important to them. Care plans were developed with people’s involvement and included specific requests from people about how they wished to have their care provided. A person had requested the staff to follow certain procedures while helping them bathe. People had requested particular days and times for bathing. A person had requested a particular care worker to accompany them to hospital. These requests had been responded to without delay.

People’s individual assessments and care plans were reviewed every three months or sooner by a care advisor or care co-ordination assistant. They were updated appropriately when their needs had changed. People or their legal representatives were involved with these reviews and were informed when the reviews were scheduled. This ensured people were able to think in advance about any changes they may wish to implement. A relative told us, “We are told in advance so we can get involved with the reviews”.

People’s care was reviewed when changes occurred in people’s needs. For example, the care advisor revisited people after they had experienced a fall or when they returned home after a period of hospitalisation to re-assess their needs. Care plans and risk assessments were updated and applications for equipment and medicines reviews were submitted to health care professionals when necessary. The staff had reported a person’s significant change in behaviour to the care advisor. The care advisor had referred the person to a mental health team and had ensured that staff accompanied the person during their specialised assessment. Updates concerning people’s welfare were appropriately and promptly communicated to staff. This ensured that people’s health needs were met in practice responding to people’s changing needs.

The provider had a complaints policy and procedure that had been updated in January 2015. People were aware of the complaint procedures to follow. One person told us, “I never put a complaint in writing because it would take too much time; I usually complain by phoning the office, mainly about not having my regular carer at weekend, but they can’t do much about that”. The manager had responded to the people who were dissatisfied and explained to us that weekend cover presented difficulties that were being addressed. The calls were covered although people were not always able to retain their regular care worker at weekend.

People’s views were sought and acted upon. Surveys about people’s satisfaction about their care and treatment were carried out each time their care was reviewed. People were assisted with expressing their views in writing when they requested it. Additional comprehensive questionnaires were sent to people that sought people’s views on specific aspect of the service’s delivery of support. Questions included, “Are your human rights respected and upheld? are you involved in making decisions about the care?; are your views taken into account?”. Further survey questionnaires about the overall quality of the service were sent annually to people, their legal representatives, and stakeholders such as health care professionals and case managers from the local authority. The last surveys had been carried out in September and October 2014. We

Is the service responsive?

noted that people were satisfied with the quality of care provided, although several people had expressed their dissatisfaction about the lack of regular care workers at weekends and punctuality.

Staff were invited to express their views at team meetings and using a comments and suggestions box that was emptied every month by the registered manager. A member of staff had suggested a change to an assessment template and this had been implemented.

Staff provided transport and escorted people to ensure they had access to day and garden centres, parks, tea rooms, hydro pools, launderettes and shopping malls. The staff gave us examples when they had supported people to become more involved in their community. A member of staff had approached a leading carer's charity on a person's behalf in order to access a regular weekly sitting service. Another member of staff had provided information to a person regarding a specialised day centre that led to them attending twice a week. These pro-active interventions ensured people's social isolation was reduced in the community.

Is the service well-led?

Our findings

Our discussions with people, their relatives, the manager and staff showed us that there was an open and positive culture that focussed on people. People told us, "I have used this agency for over five years and I have not had cause to complain, they changed my care package when I requested it and they do exactly what is needed", "The workers are competent, well trained and well organised" and "The managers are really nice". The staff told us, "We are well trained and we are a good team, with a good manager whom we can talk to".

Several people told us that their calls to the office were not always returned when requested. Some members of staff we spoke with raised concerns regarding how the care visits were scheduled and co-ordinated, as they regularly led to late or 'time-squeezed' visits. They told us, "Schedules visits sometimes overlap and we cannot be in two places at once" and, "Sometimes I get a call from a care co-ordinator who wants me to change a shift right in the middle of my visit when they should wait until I have finished". We discussed this with the registered manager and the director who were aware of the problem and who had already taken action to remedy this. The registered manager said, "We are aware of this as I have listened to the staff and people's concerns and comments about this; I have taken a certain course of action and I plan to improve this crucial aspect of our service. Good co-ordination is the key to effective care and people's rights to prompt reliable care must be protected". We found that the action taken was appropriate. The director told us, "The system of care co-ordination will be improved and this is a part of our improvement plan for the service".

At the last inspection on 6 May 2014 we found that there were not sufficient effective systems in place to regularly assess and monitor the quality of service that people received. At this inspection, we found that appropriate action had been taken to remedy this and ensured the provider achieved compliance with the Regulation 10 of the Health and Social Care Act 2008.

A system of quality assurance checks was in place and implemented. Staff's practice was monitored by a quality care officer through regular unannounced 'spot checks' that recorded staff's timeliness and performance. Each care worker was checked at least once every three months and additional supervision or training was provided when shortfalls were identified. This action ensured that people were supported by staff who maintained their knowledge and skills.

Audits were carried out to monitor the quality of the service and identify how the service could improve. These included audits of documentation that were regularly carried out to ensure that all care plans and risk assessments were appropriately completed and maintained. Regular audits relevant to health and safety in the office and audits of accidents and incidents were carried out every two months by an internal health and safety officer. They reported their findings to the registered manager so they could identify common triggers and minimise further risks. Audits of equipment checks in people's home were carried out to ensure they were serviced regularly. All satisfaction surveys and people's complaints were audited by the manager to identify how the service could improve. The last satisfaction surveys dated December 2014 showed that 62% of people who took part were 'extremely satisfied' about the overall quality of the service and 23% found it 'Good'. Key areas for improvement had been identified as a result, such as weekend staffing levels.

The manager had implemented changes in the service as a result of these audit checks. This included a new monitoring system regarding the administration and recording of medicines and a new system to gather people's feedback in order to identify how the service could improve. Weekend staff had been recruited and a system of 'standby' care workers had been implemented. Recruitment was in progress and on-going.

Staff had easy access to the provider's policies and procedures that had been reviewed and updated in January 2015. Attention was paid to changes ahead of new legislation that could affect the service. All staff had been informed when updates had taken place. This system ensured that the staff were aware of procedures to follow and of the standards of work expected of them to provide safe, effective, responsive care and support for people.

Staff were encouraged to make suggestions about how to improve the service. There was a staff suggestions and comments box that was emptied by the manager every month. However the staff told us they preferred to talk and discuss practice issues during team meetings. A member of staff had suggested a template for records could be

Is the service well-led?

improved and this had been put into place. Staff's concerns about how their schedules were co-ordinated had been taken in consideration and appropriate action had been taken by the manager.

The manager formally met the deputy manager every month. They both attended several meetings with staff which were recorded. These included a monthly meeting with the care co-ordination team and the human resources team; meeting all care staff every two months; and holding a 'care review' with the care quality officer, the care advisor and assistant every three months. Varied issues about the running of the service were discussed, such as staffing levels, spot checks outcomes, new policies, and "Moving forward" about how to improve the service.

The registered manager spoke to us about their philosophy of care for the service. They told us, "I want people to feel safe, as independent as possible, to feel they are listened to, and be confident that they are cared for by competent, well trained dedicated staff". We found that staff were putting this value into practice when providing care for people.

Members of staff were welcome to come into the office to speak with the management team at any time and we saw that they approached them in the office several times during the day. All the members of care and office staff were complimentary about the manager and their style of leadership. Staff told us, "The manager is brilliant, very caring and very approachable", "I cannot praise the manager enough; This is not just a '9 to 5' job to her, she lives and breathes for this service" and, "Our manager and deputy manager are fantastic – they're diamonds".

The registered manager notified the Care Quality Commission of any significant events that affected people or the service. Records indicated the manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe, and kept people's families involved in decisions concerning their family members' safety and welfare.

People's records were kept securely. Archived records were labelled, dated and stored in a dedicated space. They were kept for the length of time according to requirements and were disposed of safely. All computerised data was password protected to ensure only authorised staff could access these records. The computerised data was backed-up by external systems to ensure vital information about people could be retrieved promptly.