Springfield Home Care Services Limited

Positive Life Choices (Newcastle)

Inspection report

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Date of inspection visit:
12 February 2018
19 February 2018
21 February 2018

Date of publication:
25 April 2018

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

This inspection took place on 12, 19 and 21 February 2018 and was announced. This was the first inspection of the service since the registration changed in December 2016.

This service is a domiciliary care agency based in Newcastle. It provides personal care and other additional support to people living in their own homes throughout Newcastle and North Tyneside. Services were provided to adults with a wide range of health and social care needs including physical disabilities, sensory impairments, learning disabilities, mental health needs and people living with dementia. At the time of our inspection there were 104 people receiving a service.

Not everyone using Positive Life Choices (Newcastle) receives regulated activity; The Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

The service had a registered manager in post. The registered manager has been in post since the service registered on 9 December 2016. A registered manager is a person who has registered with the 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.

Medicine management had some areas to improve upon, including ensuring the full completion of medicine administration records and ensuring that any support given by others was correctly recorded and monitored. The provider needs to ensure guidance in the National Institute for Health and Care Excellence (NICE) guidelines if followed by all staff.

Risk assessment were not always in place, fully completed or regularly reviewed for people. This included, for example, people who were at risk of having an epileptic seizure or those at risk from diabetes. This meant people were not always protected from harm as much as they could have been because staff did not always have the written guidance to keep people safe. Accidents and incidents were recorded and monitored for trends and any learning was discussed through meetings and quality monitoring procedures. Emergency plans were in place should an unpredicted event occur, for example, very poor weather conditions.

There were enough staff employed at the service, however further improvement needed to be made on rostering systems and continuity of staff to fully meet the needs of people who used the service. People and relatives told us that they had, on occasions, too many different staff attending to their needs and that rota's changed with little or no notice. We also saw evidence of positive responses taken by the provider to change people's care calls when asked, because of hospital appointments or days out.

A continuous programme of staff recruitment was in place to maintain and grow numbers of care staff.

Induction, training and continuous support procedures were in place and people thought staff were well trained to help them, but a small number felt they needed to remind some staff regarding moving and handling instructions. New Care Coaches were in place who gave additional support to newly appointed care staff. We found some gaps in areas of support, for example supervision and appraisal procedures, however, staff still felt supported.

The provider monitored missed calls, however was not able to do this robustly as they relied on staff reporting missed calls or the people themselves ringing in to report this to the office.

People felt safe with staff who visited them at home. We observed staff who knew people's needs well. One person said, "Safe as I can be, yes." People and their relatives told us that staff listened to them, were caring and often went the 'extra mile'. Staff were respectful of people and treated them as individuals. The provider had organised a Christmas party for people to attend at a local venue. Staff told us the provider had several incentives in place, including recognising staff that go 'out of their way' to provide good quality care.

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. Staff were able to support people whose communication needs were diverse, including those who spoke other languages other than English and we saw examples of this.

People's needs were assessed and care planned in an individual and person-centred way, which included detail of people's likes and dislikes and personal circumstances. People received suitable nutrition and fluids based on their own care needs and were happy with this as were their families.
A variety of health care professionals, including GP, dietitians or specialist consultants were involved in people's care as and when this was needed and staff supported people with any appointments as necessary.

Complaints had been recorded and investigated by the provider in line with their policies and procedures. Although people and relatives knew how to complain or raise concerns, a small number felt they were not always listened to by office staff. We have asked the provider to review their processes regarding this.

The provider had received many compliments from a variety of people and families.

People and their relatives we spoke with felt overall that the service was well run and positive comments were received regarding management. Although we received some less positive comment on the communication systems within the office environment, including inability at times to pass messages on.

Audits and quality assurance checks had been completed at the service. Including checks of medicine procedures. These checks had not always found the issues we had during our inspection.

People had been given the opportunity to feedback through surveys send out and analysed on return. Feedback was also sought through care plan review meetings. Management had taken action where this was required, although needed to ensure actions were fully recorded in all cases, including due completion dates. We noted that the issues people had raised in surveys matched the issues we had found during the inspection.

We found two breaches; Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment and Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to Good governance.

We made a number of recommendations (four), in relation to rostering and missed call procedures, moving and handling procedures and office procedures.

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 consistently safe.

Medicines management needed some improvements as did the risk assessments completed to keep people safe.

Recruitment processes were in place but improvements needed to be taken.

Safeguarding incidents and concerns and accidents and incidents were reported and investigated.

People said they felt safe in the care of the staff who supported them.

Is the service effective?

Good

The service was effective.

Care was appropriately assessed and planned.

Staff received induction, training and felt supported, although some gaps were found.

Consent was sought in relation to people's care and treatment. People and their relatives were involved in care planning and told us they received suitable food and fluids.

Healthcare professionals were involved in people's care as required.

Is the service caring?

Good

The service was caring.

Staff listened and understood people's individual and were kind and thoughtful.

People were treated with dignity and respect. Including, for example, people whose first language was not English.

Staff encouraged independence wherever possible.

Is the service responsive?

Good

The service was responsive.

People received care which was centred around the individual involved and detailed in care plans. The provider had been flexible to change, including changes to care calls when needed.

People and their families knew how to complain, although we have made a recommendation from comments we had from a small number of people and relatives.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Notifications had not always been submitted to the Commission as legally required.

Audits and checks were completed but they had not always found the issues we had during the inspection.

A registered manager was in place and we received positive comments about the whole management team.

Feedback was sought from those who used the service to ensure continued improvements were made.

Positive Life Choices (Newcastle)

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 visit commenced on 12 February 2018 and was completed on 19 and 21 February. We gave the provider short notice of the inspection because we needed to ensure the registered manager and other key staff would be available at the office when we visited. One inspector visited the office location on 12 February to see the registered manager and staff; and to review care records and other documentation regarding governance.

The inspector visited people in their homes and an expert by experience conducted telephone interviews with people who were receiving care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we reviewed information we held about the service, including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

We contacted the local authority commissioning and safeguarding teams and the local Healthwatch to obtain their views about the service before our visit. Healthwatch is the local consumer champion for health and social care services.

We spoke or met with 14 people and 12 relatives to gather their views about the service. We also spoke with

six care staff through telephone calls or when we visited people in their homes. We met and spoke with the registered manager, the service manager, the regional operations manager, the regional trainer, two supervisors, a care coordinator and two care coaches.

We contacted four care managers and one social worker from the local authority, one community nurse and one GP. From those who responded, we used their comments to support the inspection process and judgements made.

We reviewed a range of eight care records, including medicines records. We looked at six staff personnel records. We also checked records relating to the management and governance of the service.

Requires Improvement

Is the service safe?

Our findings

Visits were made to people who received services in their homes by the inspector. We aimed to check medicines procedures were correct and people were receiving safe care and treatment.

Although people and their relatives felt that the provider managed their medicines appropriately, we found some shortfalls which needed to be addressed.

We found incomplete medicine administration records (MAR) in place, particularly for those who were supported with reminders to take them as in line with the National Institute for Health and Care Excellence (NICE) guidelines. We also saw that a number of people were supported by their family members to receive their medicines. This support was not fully recorded on the MARs and meant a full history of medicine administration was not available. We noted that some entries on the MAR, for example, those marked as 'other' should have had an explanation of what that meant on the back of the document but did not. One person who dispensed their own medicine into a 'pot' was then handed the pot by staff but this had not been risk assessed to ensure it was done safely. Another person had no list of current medicines on record which meant staff could not be assured they were receiving all the medicines they should have been. People did not always have a full separate list of their medicines available to staff so they could ensure those dispensed matched what people should have received.

Topical medicines which needed to be used in a particular time scale, for example, eye drops within 28 days of opening; did not always have the date of opening recorded. Topical medication refers to, for example, applications to the body surfaces of a selection of creams, foams, gels, lotions, and ointments. We found one person's eye drops dispensed in December 2017 had no date of opening, so we could not be assured they were still suitable for use. However, the provider later established that the family had opened the eye drops recently.

Some of the 'as required' medicines did not have clear information on how staff should support people. 'As required' medicines are those used at times for specific issues, such as, for pain relief. For example, one topical medication stated it should be applied in the morning, while on the person's body map it stated simply 'as required' which would have been confusing to care staff. We also found that one member of staff had only applied to one part of body but not the other part as it was recorded.

One person we visited was prescribed Fortisip. Fortisip is a nutritional supplement and usually needed to be consumed within four hours of opening unless stored in a fridge. Staff usually left the Fortisip with the person between visits. We saw two opened cartons of the product with the person. The provider however, had no system in place to ensure that the person was not drinking out of date products, for example, by marking the date and time of opening on the carton.

We spoke with the provider about these issues and reminded them of the need to follow best practice from the National Institute for Health and Care Excellence (NICE). We passed all the information of concern over to the registered manager and service manager and they said they would address them immediately.

Risks assessments had been completed to help protect people from possible events which could have led to harm being caused. For example, people had risk assessments in place for skin care, choking and moving and handling. These assessments detailed what control measures needed to be taken by care staff. One person had a falls risk assessment in place which detailed, "Staff to make sure [person] uses her Zimmer frame to move around the house" and "Staff to actively risk assess the environment [person] is in and remove any obstruction."

The provider used a scoring mechanism within each risk assessment. For example, the person with the falls risk assessment was placed at a risk rating of 12 (high) in relation to the use of their Zimmer frame. It was recorded that if staff implemented the control measures the rating would be reduced; but the recording was in two parts. This meant there was no clear correlation between the original risk of 12 and the reduced rating. We saw that a small number of risk assessments were not in place, for example, one person who had behaviour which challenged the service had not been risk assessed. Another person had no risk assessment in place for their epilepsy, while another person had no risk assessments in place at all, even though they were at risk from epilepsy and were diabetic. Another person had Fortisip prescribed but this was not included as part of their control measures on their nutritional risk assessment. We spoke with the registered manager and service manager about this and they said they would address these issues straight away.

These issues constitute a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in relation to safe care and treatment.

Although we found issues with medicines management, people felt that care staff supported them safely with their medicines. Comments included, "They know exactly what to give me"; "They are brilliant"; "They bring coffee with my meal, then they set out my pills whilst they are waiting for the kettle to boil"; "They watch me whilst I take my pills" and "They give me my pills four times a day, they do everything properly, on time, with a cup of coffee. First class. They always ask if there is anything else you need." One relative said, "Mam is a diabetic so regular meals and medication is important, she gets her medicines on time." Another relative explained that care staff supported their family member to go out for a meal and gave them their medication whilst out. The relative confirmed medicines were given correctly.

People and their relatives said the service was safe. Comments from people included, "I am very safe, thank you"; "No problems with the girls"; "Safe as houses" and "All good here." One relative (nurse by profession) said, "They are very caring. If mam's poorly they are on the ball, get the GP and ambulance and ring me as well. From my point of view, a nursing point of view, the service is safe." Another relative said, "I have no worries about safety. I am confident leaving staff here to look after [person's name], otherwise it would not happen."

The provider tracked safeguarding events through their governance procedures. The registered manager and service manager investigated all safeguarding incidents we viewed. Actions taken included sharing lessons learned through staff meetings. Staff had received safeguarding adults training. Communication with staff confirmed they would report any concerns they had in relation to protecting vulnerable people from harm if they suspected any wrong-doing.

Accidents and incidents were recorded and monitored and where necessary people's individual risk assessments and care plans were updated following any incident.

Personal protective equipment such as disposable gloves and aprons were used by care staff performing care duties in people's homes. People and their family members confirmed this. During visits to people in their homes we observed staff using suitable infection control procedures (including using gloves and

aprons) to protect people from cross infection or the spread of disease.

We received some mixed views about the rota system and the continuity of staff. Some people thought that the system was good and worked well with constant staff teams attending. Others thought that the rota changed too often with no notice and they had too many different staff attending to their care needs. Where people had more complex care calls, staff, overall, remained constant. Other comments included, "I have regular carers; not at first, but now, which is what I want"; "They can be late four times a week, from ten minutes to two hours"; The carers are quite reliable, they are wonderful carers, very good"; "They are sometimes late as they are over the other side of the city. If they are off, one of the girls will tell me who's coming. I have a rota but it's only a guide, things can happen"; "I get mainly regular staff. If they are off we don't get told who's coming but I know them all well"; "They are pretty punctual" and "I get the same carers apart from tea time." One person told us, "Two girls arrive together, sometimes one comes later if they are busy, they sometimes ask me to help."

We asked the service manager to provide us with a report for the last few months which showed us the continuity of staff to each person. We looked at the period from November 2017 to February 2018. Information showed that some people had a larger amount of different staff to support them than others over the same period. For example, one person who received 440 visits had five staff covering while another person who had 368 visits had 40 staff covering the same period.

A few staff we spoke with told us that they did not understand how the rotas were calculated on occasions and felt more planning was needed. One staff member said, "I have been known to travel to the other end of town when carers who live closer would have been better." Another staff member said, "It must be hard to decide who is going where, but sometimes it just feels like a bit rushed and could be done better." A further member of care staff said, "I tend to have the same people to visit."

The registered manager told us they had been short staffed in the department which deals with the rostering systems, but said a new employee was due to start soon.

Missed call reports between May and October 2017 showed 13 missed calls recorded. The only way the provider knew if people had not received their care call was if the person called the office themselves or a member of staff reported a missed call from the previous shift. After visiting one person we saw a missed call which was not included in the missed call logs as the provider was unaware. This meant the provider had no robust system in place to monitor missed calls.

We recommend the provider review the rostering and missed calls procedures and ensure that a robust system is implemented.

Emergency procedures were in place. An 'on-call' service operated outside of normal business opening hours. A log was kept of any calls made during these times and information passed over to day staff for action if necessary. The provider also had a business continuity plan in place. The plan was based on several risk areas including, loss of the building, documentation being lost or staff not being able to support people due to staff shortages or poor weather. All the listed risks were classed as low probability and included preventative measures and what action to take should the situation arise.

We looked at the staff files of six staff, including care staff and office staff, some of whom were newly appointed. Application forms were in place, interview documentation, suitable references had been obtained and an enhanced check with the Disclosure and Barring Service (DBS) had been undertaken. DBS check a list of people who are barred from working with vulnerable people; employers obtain this data to

ensure candidates are suitable for the role. We noticed that one staff member had a query relating to one of their references that the registered manager and service manager was not aware of. They told us that all references that are not 100% satisfactory should be signposted to them. They said they would look into this and speak with the human resource staff.

The provider had a continuous recruitment programme in place and this was to ensure that if sickness or holidays were to prevail, other staff could be called upon.

Good

Is the service effective?

Our findings

An initial assessment of needs was carried out for people who required support from the service. This was completed prior to receiving support and usually in the person's home or hospital. Once accepted into the service a full and detailed care and support plan was established with input from the person, their family and any other health and social care professionals involved.

The people and relatives we spoke with thought carers were mainly well trained and competent and effective in the care they delivered. One person said, "They are generally punctual, they have generally a lovely attitude, very helpful and competent." Other people told us, "They are good some of them, the students [new staff] have a lot to learn, but if they've had a family they are used to handling and changing, they are very competent"; "The girls [care staff] are generally competent with moving and handling, the problem is when there are two inexperienced carers together"; "The carers are very nice. There are occasional language barriers. They do work horrendous hours"; "I could not fault them in what they have done. Fantastic, the lot of them" and "They do a hard job for poor pay, but that's care work for you."

One family member commented on how the care staff had integrated into the family and said, "They are brilliant. It's a testament to the carers. They have all given us a sense of worth and manage [person's name] very effectively indeed." They continued, "[Care staff name] does not realise the qualities she's got. Very good, rest of staff are good too."

We received some negative comments about the communication within the providers office. One person told us, "I don't think the office know how hard the girls [care staff] work. They have them fleeing all over the place." Other comments included, "They [office staff] contact occasionally, normally I have to chase them up. I ring the office or the out of hours number; sometimes they answer sometimes they don't"; "When I ring the office they are apologetic, but it's not a genuine apology, I feel I am bothering them"; "We don't always get told when changes are going to take place, which is not very good. I know it's a busy service, but how long does it take to make a quick call rather than just have someone different turn up." We spoke with the registered manager about this and they said they would look into the comments made.

The provider had recently introduced a new role into the service, 'care coaches'. We were told three staff had been appointed to this role. Current care staff had been appointed and it was an add on to their caring roles and a development opportunity. We were also told that staff in this role would receive an additional payment for successful completion of a staff members induction and probationary period. Care coaches provided additional tailored support to newly appointed care staff and other less confident care staff. We spoke with two Care Coaches and they were looking forward to fully embedding the role into place. One explained how they had buddied with one person and said, "It is working well so far."

New staff had received a comprehensive induction, in line with the Care Certificate. The Care Certificate is a benchmark for induction of new staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective and compassionate care. Newer staff we spoke with said that they felt the induction process was adequate to give them an insight into the organisation and any

processes or procedures they needed to know about. One staff member said, "New staff receive support from a mentor now and have a minimum of two weeks shadowing. They are then signed off."

The provider had a full training programme and their own regional trainer who was based at the service. We looked at the schedule of training and found training had taken place across of a range of areas which the provider deemed mandatory, including first aid, medication and moving and handling. No person or relative we contacted said there had been any issues caused because of poor moving and handling. One person said, "I have no concerns about them hoisting me from the bed to the toilet, no problems whatsoever." We asked a relative if they had any concerns about the moving and handling of their relative. They said, "Everything is fine. They take [person's name] out to the Metro Centre which she likes a lot, she goes to McDonalds and KFC." However, a small number of people/relatives commented that they had to constantly remind staff how to move and handle correctly.

We recommend the provider reviews its moving and handling procedures in light of the comments made by some people.

We found some gaps in supervision and yearly appraisal sessions with staff. Supervision and appraisal systems are forms of support from line managers and opportunities for reviewing training and development with staff members. Staff, however, told us they felt supported. One staff member said, "I can speak to any of the management team. They have all been very good." Another member of staff said, "I feel supported, yes. We have regular meetings too." A Care coach told us, "Training was very good. When I needed help I just asked and [supervisor's name] came out and sat and went through medicines with me as I wanted to make sure I was doing it okay. Can ring or call anytime." The provider was aware of the gaps and was working through these.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We observed that the service had assessed people's capacity upon initial referral and used local authority assessments to support this.

There was one person subject to a court of protection order from the records of people we viewed. The Court of Protection advocates on behalf of people who are deemed to lack mental capacity and makes decisions on their behalf. Staff had received training in the MCA. The registered manager and service manager were aware of their responsibilities in line with the MCA. Copies of lasting power of attorney (LPA) were kept if people had these in place. (LPA) is a way of giving someone you trust the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. There are two types of LPA; those for financial decisions and those that are health and care related. The management team said they would ensure they would keep copies of these documents in future.

Although we were not made aware of any best interests' decisions being made for any person, the registered manager was aware they needed to record these appropriately and in partnership with any relevant others, including family or healthcare professionals.

People told us that they were asked for their consent and given choice. One person said, "They always ask is there anything they can do; what would you like for tea. They look after us." One relative said, "They offer choice more or less. They get him in the shower, do the job; back in the chair, stockings on. He talks to them,

they have interacted with him very well." Observations were made of people being involved in decision making. Staff asked people how they wanted care tasks completed, including supporting one person with their eye drops. The staff member said, "Shall we do your drops now [person's name]." When the person positively responded, they continued to provide the support while speaking to the person throughout to confirm they were still happy.

During visits we saw evidence that where nutrition and hydration were part of a person's care needs, staff supported them well. Comments included, "I tell them to make me a cup of tea and they do it, no problem… I would complain to them if I needed to, but never have had to"; "They always ask me what I want for lunch, or make me a sandwich for later if I don't want it then" and "They serve my meals, the girls are great as long as they are the same ones. They know me, which is why I want the same people." One person told us that care staff made them drinks at each call and heated up their meals. One family member said, "They give Mam breakfast. I prepare most of the meals, they get it out, there are no issues with how they do this." Records confirmed that staff had provided a range of suitable food and refreshments to people.

Staff had supported people to maintain their health and wellbeing. Where issues had been found, including weight loss or swallowing difficulties, people had been referred to appropriate healthcare professionals, including GPs or speech and language therapists to further support them. Family members told us that care staff had highlighted any concerns with their relative's health and ensured they received appropriate support.

Good

Is the service caring?

Our findings

Everyone we spoke with said that staff were caring and many went "the extra mile". One person said, "Yes they are friendly. They just talk and make you feel comfortable. They are not just doing what they need to." Another person said, "They are generally very friendly, very nice people. I complained about one person; I asked her not to come again, it was dealt with quickly with great understanding." Other comments from people receiving care included, "I get well looked after. The service is excellent"; "They [care staff] are caring, they are like that all the time"; 'The girls on the ground are fantastic. No matter how rushed, they are always good"; 'Everything is good, they could live in!... that would improve the service, they do a great job within the time; they do their best" and "I have nothing but praise for them, they are very kind."

One relative said, "They are really canny [nice] with mam, she likes them, she's got used to them." Another relative said, "Staff are lovely. Small group of them. They have been coming for years. Nice people."

People told us the care staff were kind. One person gave an example of how kind the carers were and said, "They gave me some flowers for my birthday." Many compliments had been received by the service. One dietitian had complimented two care staff for supporting one person with a healthy weight gain. One family had complimented a carer for 'going above and beyond'. The service manager had organised a Christmas party for people who used the service to attend. This had been held in a local venue and we were told that it had been well received. We viewed pictures held in the provider's office of people enjoying themselves from the event.

People had an opportunity to talk to care staff and felt listened to. One person said, "Yes they listen to me, I chew their ears off!" Another person said, "The girls are alright, they chat and are friendly. They do everything for me." One person who had communication difficulties could express their wishes through face gestures and via picture cards which staff had introduced. This was recorded in their care plan preferences. We were able to confirm this with the person's family who said, "The staff know [person] very well. They are marvellous. They can tell what [person] wants as well as I can."

People felt that staff treated them with respect and maintained their dignity. One person said, "They are respectful all the time." When I asked what was good about the service one person said, "They treat me with respect." Other comments included, "Very respectful, yes"; "I am as respected as I should be" and "I have seen how respectful they are with her. They treat her as I would expect them to."

Confidentiality in relation to the people who used the service was important to the provider. They had identified staff who had not always maintained this as fully as they should have and this was dealt with effectively. Data protection was a regular topic in staff meetings and reminders to staff were sent in various forms of communication they received. One staff member told us, "Staff are told right from the start as part of training about confidentiality, so there is no excuse." Copies of people's care records were stored in locked cabinets within a secure building, with access only available to relevant staff.

From the visits we made to people in their own homes, staff showed a good understanding of their needs.

One staff member knew how one person liked to have their meals prepared for them in a particular way and how to set it down in a specific place. Another staff member had a good relationship with the person they cared for and knew how they preferred their medicines administered. One person said, "They [care staff] know what I like."

Staff could demonstrate how they had sought accessible ways to communicate with people. Staff told us how they supported people and their families whose first language was not English. The provider employed staff with a range of communication skills, including the ability to translate various languages, for example, Urdu and Punjabi. The service manager told us that they had been able to communicate with people and their families and enable them to feel fully involved in the care planning process. Staff also gave us an example of one person whom they had previously used picture cards to support them in their communication needs. This, at the time, had helped care staff to gain a better understanding of the person's needs.

Care plans were established to ensure people's needs were met in a way which replicated their individuality. Staff attended equality and diversity training. When speaking with staff it was clear that they used this training to support and promote individuality and ensure people's personal preferences, wishes and choices were respected.

We asked if people had been involved in decisions about their care and support. One person said about their care plan, "They fill it in, I check it with them." Another person said, "I've read some of it, they are writing about me." One person said about her care reviews, "There is nothing different that I want, they understand perfectly, the girls do a fantastic job, they are careful of their times." One relative said, "I feel involved, they help my daughter pick out her own clothes when she's shopping."

People and their families said staff supported them to be as independent as possible. One person told us, "I have a wheelchair and a walking frame, I want to do it myself, but getting my legs straight is very painful. They don't rush me and I can't fault them." Another person said, "There are times when I need help getting up, they hold back for a second. I attempt to get up, then they know to help." One relative said, "They always give [person] the flannel when they are washing her, they encourage her to roll over when changing the pad, they encourage her to put her arms through when they are changing her top." They continued, "They have the music on and sing and dance with [person], they do plaits or a bun with her hair; to me the staff go the extra mile, they treat [person] as the teenager she is. They have a daft carry on; the giggles and laughter coming out of her room, it melts my heart."

The provider had procedures in place to ensure that people were provided with additional representation and support should they need it. We were not made aware of any person who used an advocate as many had relatives or friends who acted on their behalf. An advocate is a person who represents and works with people who need support and encouragement to exercise their rights. The service manager gave us information about the advocacy services available in the areas they covered, including details of how to refer people should they need that level of support. One staff member we spoke with told us, "Many of the people we work with have families who help them, but if someone had nobody, we would get them the help they needed. I would ring the office and ask for advice."

Good

Is the service responsive?

Our findings

Staff had collected people and family views about how they wanted to receive personalised care which met their needs and which reflected any changes that may occur. One relative told us staff had devised a contingency plan with them to ensure their family member remained safe should they fall ill. They said, "We've discussed the care plan with them, and discussed what needs to be done when I'm poorly myself, everything's been great." Another relative said, "They always ask mam if she wants a shower or a wash down, they attend to that."

New care planning paperwork had been implemented and the provider was currently working their way through people's records to update them. Care plans included person-centred information, for example, people's communication preferences, individuals who were important to them, lists of important dates (birthdays or anniversaries) and daily routines. The level of detail was good, including for example, what colour sponge to use or a note for staff to ask the person what type of deodorant they wanted to use. Each area of need, for example, relating to personal care or medicines, included goals and outcomes which the person aspired to achieve. This included one person who wanted to remain independent as much as possible. Care plans also included a high level of detail which supported staff to better understand each person's care needs. For example, one person had a medical condition which made them more susceptible to skin problems and seizures. The plan detailed what staff should do to maintain this person's health, including routines to follow.

People had their care needs reviewed. One family member said, "We had a review last year with the manager. They rang me; mam and I both signed the care plan." However, a small number of people and relatives, told us they had not always had a review of their care needs recently completed. Some people said they had not received a review, but an assessment visit when they commenced the service. One person said, "I've not had a review for a good while." We were made aware that due to staff changes, the provider was behind in completing reviews. We were told these would be completed as soon as possible.

During a review of the providers IT system, we saw that people were treated in a flexible manner with regards to their care calls. Requests for changed or cancelled calls were seen and we noted that the provider had rearranged these at short notices. One family member told us, "We have altered staff many a time when we needed to change things around. It has never been a problem. They [provider] are very accommodating."

At the time of the inspection, the service manager reported that no person was receiving end of life support. Some people's records included information about advanced decisions they had made about treatment in the case of an emergency. For example, the provider had recorded information about people who had authorised 'Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)' forms in place. A DNACPR form is a document issued and signed by a doctor, which informs healthcare professionals not to attempt cardiopulmonary resuscitation.

When staff had fallen short in expected care delivery, the provider had responded appropriately. One

relative told us that a member of staff had not been very approachable and had "not got on well" with their family member. They said the provider removed the staff member from the care calls immediately and replaced with another member of staff. They said, "[Person's name] was delighted." Everyone we spoke with said they knew how to complain and would complain if they felt they needed to.

One person told us they had complained to senior staff recently as one member of care staff had "done nothing" on their care call. The person thought the senior staff who visited them were 'lovely' and the carer had not been back. They said that the provider was in the process of ensuring they had visits from staff they liked. When we checked complaints recorded we found the provider had addressed these appropriately, including speaking with care staff and initiating their disciplinary process when necessary.

A small number of people and relatives thought that complaints would not be dealt with appropriately and said the office staff did not always listen to them.

We recommend the provider review office procedures in light of this comment.

Requires Improvement

Is the service well-led?

Our findings

The provider and registered manager had failed to send us all relevant notifications in line with their legal requirements. Notifications are information about specific events which have occurred at the service. For example, safeguarding incidents, police involvement or serious injuries to people. The regional operations manager showed us a copy of an email from December 2016 which had attachments from a meeting held in the previous November. One of the attachments was entitled, "CQC notifications – managers guidance". This email had been sent to the registered manager and the service manager. We are dealing with this outside of this inspection process and will report on any actions taken in due course.

Audits and checks were mostly completed regularly to monitor the quality of the service. Medicine audits had been completed to confirm staff were following safe working practices and supported people correctly with their medicine regimes. Where management had found staff not following correct procedures, measures were taken. This had included attendance at further refresher training and discussions held in team meetings or one to one support sessions. However, we found some discrepancies with medicines management which had not been found during checks completed. For example, gaps on medicine administration records (MAR) had not always been noticed. We also found where care staff had missed recording information from the back of the MAR and this had not always been recognised as missing.

Medicine competency or spot checks had not always been regularly completed with all staff. One staff member told us they had not had one for some time and were overdue. When we checked records, we found a number of staff were overdue too. The registered manager and service manager were aware of these gaps and were working to address this. Daily records were checked when they were returned to the office by staff. When issues had been noticed, actions were recorded. For example, discussion and lessons learnt with individual staff members or teams. We found some issues within daily records had not always been found during audits and checks. For example, one supervisor had completed an audit on February 2018 but had not noted issues or actions to take with staff not turning up on time or that scribbles in recording had been made.

The provider could monitor the service via their IT system, which allowed a range of reports to be produced. For example, monthly or quarterly safeguarding incidents, accidents or complaints could be produced. We found that on a small number of occasions that incidents had been logged as complaints. We discussed this with the registered manager and service manager who said they would ensure this was reviewed.

These issues are a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

There was a registered manager in place. The registered manager and service manager were present during the inspection and greatly assisted us by liaising with people who used the service and helping us with any queries we had. The registered manager was also registered at another of the provider's services. We noticed from regular 'huddle' (morning) office meetings that the registered manager was not always present. We discussed the role of the registered manager and their oversight of two branches with the regional

operations manager. After the inspection they emailed us to confirm the provider intended to make changes to the registration and hopefully register the service manager at this branch to oversee day to day operations.

People, relatives and staff were positive about the management, mainly in connection with the service manager. One relative said about the service manager, "She is a lovely girl and she tries to do her best for us." Another relative said, "She seems very nice." One person told us they had spoken with a manager [registered manager] and thought they had been very helpful. Staff told us they felt supported and they could go to the service manager or the registered manager at any time. One staff member told us, "I chose to work here because I had heard positive things from someone who used to work here."

Most people we spoke with thought the service was well run. Comments included, "They are very efficient"; "I think it's well run, I don't know if they are approachable, I've never spoken to the managers" and "It's all really good. From an adult safety point of view for mam it's a service of care. Mam knows them and they know mam."

There were some negative comments regarding communication with the provider's office staff and their communication with staff, people and their families. One staff member was asked if there was anything they would change about the service what would it be. They said, "The only thing I would change is communication. You can sometimes speak to one person at the office and they don't pass the message on; although it is recorded on the system it sometimes goes a miss." We raised this with the registered manager and service manager and they said they were going to continue to review their processes to ensure that communication was improved.

The provider promoted a positive culture and had recently introduced new supervision booklets which covered key values important to the organisation, including integrity and caring attitude and skills. This meant at every support opportunity these were discussed with staff and kept at the forefront of conversations, including staff being scored against each theme, including attitude and being passionate about the work they undertook. During our observation of care staff, we found they met the culture the provider aimed for.

Meeting had taken place with staff and at management level. Staff told us they attended meeting in teams if they supported a complex care package. We reviewed the minutes for these meetings. Discussions had taken place, regarding, for example, communication and levels of care provided to the person. We spoke to one family member and they felt the meetings were beneficial and said, "We meet every now and then and go over things. The girls are very good. We have ironed out a lot of bits and pieces out at these meetings, so that is good." We noted in one meeting minutes that a consultant had been very impressed with a group of care staff.

We reviewed minutes from a recent 'Carer Forum' meeting. Carer Forums are meeting which all care staff are invited to. These meeting had discussed rotas, supervisions and issues arising with some of the people staff supported. Actions were agreed, including, for example, who to contact in the office for particular issues. We spoke with the service manager about staff attendance. They said they were currently in the process of ensuring that staff attended meetings on a regular basis and were looking at ways to encourage this.

During review of care records and visits to people in their homes, we found care staff had not always used the correct paperwork to record information. For example, on a number of occasions we found staff had used finance recording sheets to record daily notes. When we mentioned this to the service manager, they were aware and said they had already informed staff that this should not occur. They said they would

consider it again.

On occasions we found records, including for example, audits and branch reviews, did not always have details of when it was due to be completed and was not always followed up. For example, one branch review stated that a full audit of staff personnel files was to be completed by the HR department. No date was given for this to be completed and at the next branch review it was not followed up or mentioned. After the inspection the provider wrote to us and confirmed that the audit of the staff personnel files had been completed.

People and relatives could give feedback to the provider in several ways, including care reviews and surveys. One person said, "We've had a couple of reviews and endless surveys to fill in." The provider sought feedback from people to evaluate and improve the service. A survey had been sent out to people in July 2017. Once returned, the survey was analysed and the results sent out to people in September 2017. From the 29 surveys returned, the provider had identified a few issues during this process, including, poor communication, lack of consistency and complaints not always being managed appropriately. Apart from complaints not being managed appropriately, which we found they were; we received feedback from people, relatives and staff which corroborated the feedback received through the survey. Most of the surveys returned were anonymous which meant it was difficult for the provider to respond to any concerns raised. We discussed this with the registered manager and service manager and a proposal was made to include a space on the form for people and relatives to put their name if they wished to, which we felt was a positive idea.

The provider had a range of incentives in place for staff. This included a 'refer a friend' scheme. The scheme encouraged staff to entice suitable friends to make an application to work at the service. The staff member would then be rewarded with £150 voucher on completion of the recruitment process. There were recognition awards for staff, including 'you're a star' and 'random acts of care' in which staff were nominated for by going 'the extra mile'.

The providers understood their responsibilities to ensure that the rating for the service was clearly displayed once published using the CQC widget. A widget is an IT tool which can be used by anyone to enable quick access to a particular area of the internet (in the CQC's case, directly to our website and the services latest report). Registration documentation was clearly displayed in the providers offices as legally required.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider did not have robust medicines management procedures in place. Risk assessments were not always completed or fully detailed or reviewed as they should have been. Regulation 12 (1) (2) (a)(b)(g)

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The provider had not established or operated a fully robust quality monitoring system, particularly in relation to processing of notifications, medicines management and completion of risk assessments. Regulation 17 (1)(2)(a)(b)