Mrs. Gloria Ocampo

Independent Care Solution

Inspection report

63 Loveridge Road
Kilburn
London
NW6 2DR

Tel: 02076240956
Website: www.independentcaresolution.co.uk

Date of inspection visit:
14 July 2016

Date of publication:
16 August 2016

Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
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 the 14 July 2016 and was announced. We gave the provider 48 hours' notice that we would be visiting to ensure that the registered manager would be available on the day of the inspection.

The provider had moved offices in September 2014 and so this was the provider's first inspection since it had been registered at the new address. The service, when last inspected in July 2014 at the previous address had met all outcomes of the regulations that were inspected at the time.

Independent Care Solutions provides domiciliary care services to people living in the community within extra care schemes and within people's own homes. There were currently 39 people using the service. The service provides personal care to older people living with dementia, people with physical disabilities and other high care needs.

The provider was also the registered manager. 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.

Each person using the service had a care plan which contained basic information about the person and their care needs and requirements. As part of the care planning process, the service carried out generic risk assessments which covered risks associated with the environment, moving and handling and health and safety. However, although the service identified people's individualised risks, these were not assessed and guidance was not provided to care staff on how to mitigate or reduce the risk of harm.

People we spoke with told us they felt safe in the care of the staff members that supported them. Care staff were able to identify the different types of abuse and were clear on the actions that they would take if they suspected any abuse was taking place in order to protect and keep people safe.

The registered manager and care staff had a good level of understanding of the Mental Capacity Act 2005 and how this impacted on the provision of care and support. However, care plans that we looked at did not evidence that the service completed any form of mental capacity assessment. There was no recorded information of any best interest decision that had been taken on behalf of person who lacked capacity. Where the local authority had completed a mental capacity assessment, we saw documents relating to this within the care plan. However, in one particular care plan, the assessment and best interest decision did not reflect the care and support a person was receiving especially relating to the potential use of restraint.

One care plan that we looked at we noted that the support a person required involved the need for care staff to hold the persons hands whilst the second carer supported them with personal care. This could potentially be interpreted as the use of restraint. The service had not provided any training or guidance to

care staff on how this should be done in a safe and least restrictive manner as per their own restraint policy.

Care staff told us, and documents confirmed that care staff received training in the safe administration of medicines. However, on the day of the inspection we found that the service did not list the names of the medicines on the Medicine Administration Record (MAR) and care staff did not sign any records using their initials but instead used a coding system which only stated that they had observed the person taking the medicine. We were unable to identify which care staff had administered the medicine and care staff were unaware of what medicines the person was taking, when they must be given to person and what dose must be administered. For one person we found that care staff were administering eye drops but there was no record of this and there were no MAR available confirming that care staff had administered the drops.

People told us that they were very happy with the care that they received and that they had a regular group of carers that attended to their care needs.

Care plans were not detailed and were not person centred. Some care plans that we looked at had some basic background information about the person but this was not consistent within all the care plans.

The service had safe recruitment processes in place which included obtaining two references and the completion of a criminal record check prior to the care staff commencing their employment. Care staff we spoke with told us that they felt supported in their role and received regular supervision and appraisals. Records also confirmed this.

Care staff, when recruited, received an in-house induction and training in all mandatory subjects which included first aid, safeguarding, moving and handling and medicine administration. We saw evidence that care staff received annual refresher training in all mandatory topics.

The registered manager was very 'hands on' and involved in the day to day management of the service. We saw evidence of regular sport checks and observations that were completed and regular reviews taking place which were dependent on people's level of need. However, missed visits were not formally monitored or recorded.

The service had a complaints policy which was given to people using the service and relatives when the service commenced. The registered manager told us that she had not received any formal written complaints as people or their relatives would always call her directly if they had any concerns and she would make a point of visiting them immediately to resolve any issues or concerns.

Quality assurance questionnaires were completed on an annual basis from the date the person began using the service. Feedback was seen to be positive. However, there was not analysis of the results to enable learning or improvements to service provision.

We have identified a number of breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. These breaches were in Regulation 12 and 13 and were in relation to assessing risks associated with people's care and support needs, safe medicine management and assessing mental capacity and ensuring that best interest decisions are made in collaboration with all involved and recording this within the care plan. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe. The service did not assess people's individual risks associated with their care in order to mitigate or reduce risk to ensure people's safety.

Medicine administration was not delivered in a safe way. Medicine Administration Records did not list the full details of the medicine that was to be administered and staff did not sign with their initials to confirm when people had received their medicine.

Care staff knew what safeguarding was and the steps that they would take to report any suspected signs of abuse to ensure people's safety.

The service had safe recruitment processes in place so that only suitable care staff were employed.

Is the service effective?

Requires Improvement

The service was not always effective. The service did not complete any form of mental capacity assessments especially where it had been identified that a person lacked capacity and required specific care and support which included possible restraint.

Care staff received an informal induction when they started work with the agency. Following this, each care staff was required to attend training which covered mandatory topics that included moving and handling, first aid and safeguarding.

People were supported with their health and social care needs by the agency and care staff where required.

Is the service caring?

Good

The service was caring. People and relatives told us that they were happy with the care and support they received and that they had built positive relationships with the regular care staff that supported them.

People told us that care staff were kind and compassionate and treated them with dignity and respect.

Care staff knew what person centred care was and were able to describe how they would support people based on the model of person centred care.
People and relatives told us that they felt listened to and that care staff supported them according to their needs and wishes.

Is the service responsive?

Good

The service was responsive. People's care needs were assessed prior to them receiving care and was reviewed on a regular basis based on their level of need and support.

A complaints policy was available and was also given to people and relatives when the service began. The service had not received any formal complaints.

People knew who to complain to and felt confident that their concerns would be listened and acted upon.

Is the service well-led?

Requires Improvement

The service was not always well led. Missed visits were not monitored or analysed in order to identify trends and improvements which could be made.

Medicines were not always being managed safely. There was a lack of understanding of ensuring that people who lacked capacity received safe care and support as defined under the Mental Capacity Act 2005 (MCA).

People and relatives knew who the registered manager was and were complimentary of the way in which the service was managed from a day to day perspective.

Quality assurance questionnaires were completed on an annual basis from when the person began receiving a service. People and relatives confirmed that they had completed a questionnaire. Responses seen were positive

Independent Care Solution

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.

This inspection took place on 14 July 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to support with the inspection process.

The inspection was carried out by one inspector. The day after the inspection, an expert by experience made phone calls to people using the service, relatives and care staff members to obtain their feedback about the service that they received. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

As part of the inspection we visited three people in their own home, with prior consent, to speak with them about the care and support that they received. We spoke with two people using the service and three relatives. We also looked at the agency records kept at the person's home. In addition to this we spoke with a further three relatives over the telephone.

Prior to the inspection we looked at the information that we had about the service which included notifications of any incidents or safeguarding issues which may have affected the safety and wellbeing of people. We also contacted a number of health and social care professionals who have had involvement with the service to obtain their feedback. However, we received very few responses to the questions we asked.

During the inspection we spoke with the registered manager and five care staff. We looked at six people's support plans and other documents relating to their care including risk assessments and medicine records.

We looked at a number of other records held by the agency which included seven care staff files, staff training records, policies and procedures, staff meeting minutes, spot checks and quality assurance questionnaires.

Requires Improvement

Is the service safe?

Our findings

People and relatives we spoke with told us that they felt safe when receiving care and support from care staff. One person when asked if they felt safe told us, "Safe, it's never been a problem." Another person stated, "They [care staff] are trustworthy." Relatives commented, "Yes, it is safe when they come around" and "Yes, when they are cleaning they will always make sure the safety barrier is up on the bed." Despite these positive comments we found that some aspects of the service were not safe.

Each person using the service had a care plan which included information about the care and support that the person required. As part of the care plan the service completed risk assessments which looked at potential risks within the environment as well as risks associated with health and safety and moving and handling around the persons home environment. As part of the risk assessments care staff were provided with guidance and direction on how to mitigate or reduce risk to ensure the person's safety at all times. However, although the service identified people's individual risks such as risk of urinary tract infections, falls, skin breakdown and challenging behaviour, the service did not assess the level of risk and did not give care staff specific guidance and instructions on how to manage this risk and support the person safely.

Care staff that we spoke with knew about generic risks and the risk assessments that the service completed. One care staff told us, "Yes we do risk assessment things like wires on the floor, everything is out of the way in case they fall down. Make sure they are safe as accidents can happen."

For one person, it was noted within the care plan that care staff were potentially using restraint methods in order to support the person with their personal care. The care plan stated, "One carer has to hold the hands of the client because they will hit the carer and kick as well." A risk assessment had not been completed for this identified risk and staff had not been provided with clear guidance or training in order to support this person safely as well as ensuring their own safety when supporting the person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people receiving care required support with the administration of their medicines. We looked at the medicine records for four people. Three people had a Medicine Administration Record (MAR) within their care plan, however, the MAR did not list any of the medicines that the person was prescribed and taking. The MAR only recorded the detail of the medicine as 'Blister Pack 1'. The MAR chart also did not detail when the medicines must be given, what the dose is and any special information, such as giving the medicines with food.

Care staff, where support had been given to administer medicines, used a coding system to record on the MAR that the medicine had been given. The coding system included 'D' for declined, 'T' for observed taking and 'M' for medication missing. The MAR did not identify which staff member had supported or administered the medicine. All MAR's that we looked at only recorded a 'T' for observed taking.

For one person whom we visited in their own home, we found that the person had been prescribed eye drops with which the care staff were supporting with administration. There was no MAR available and that the care staff were not signing or recording that these eye drops had been administered. We informed the registered manager of this who confirmed that she was not aware that the care staff were administering eye drops and confirmed that this would be addressed immediately.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Training certificates showed, and care staff confirmed, that they had received training in medicine awareness. One care staff stated, "Yes I give them medications as they need it. Yes, there loads of different medications and we need to train for it." However, we could not evidence that the service assessed care staff competencies once the training had been completed.

Where people required support with medicines, the service completed an authorisation form for people and/or relatives to sign confirming that they required assistance with medicine administration. The form also detailed the level of support they required.

An accident and incident folder was in place which contained completed records of any reported accidents or incidents. Detailed information of any accident or incident included the date and time of the incident, the details of what happened, a record of the actions taken and a completed body map if an injury had been sustained. There had been no reported incidents since February 2016. Records that we saw prior to February 2016 showed that the registered manager checked each and every incident that was reported to ensure that the appropriate actions and follow up had taken place. We saw records of a variety of accidents and incidents which included falls, marks, bruises and inappropriate behaviour. Care staff were noted to be very pro-active in reporting all accidents and incidents however minor they may be.

Care staff knew what safeguarding was and were able to list the different types of abuse. They were very clear on the actions they would take if abuse was suspected. One care staff member when asked about safeguarding told us, "Looking after the client, treating them as your own, equal right and making sure they are safe." Another care staff member stated, "Abuse can be physical, verbal, financial. I would report if I suspected abuse and I would record it in the care plan." A third care staff member told us, "I would report it to [name of registered manager] first and get help and support for the client." Training records showed that care staff received safeguarding training and this was refreshed on an annual basis. Care staff also confirmed that they had attended safeguarding training.

Care staff had a clear understanding of the term 'whistleblowing' and were clear about whom to report to externally where required. One care staff told us, "I can report to the local authority, the police or the Care Quality Commission (CQC)." Another care staff stated, "I am not afraid to whistle blow. I would tell the manager."

People and relatives told us that they received care and support from a team of regular and consistent care staff with whom they had formed a relationship based on trust, care and compassion. One person told us, "We have the same girls [care staff] and they know what to do." Rota's we looked at also confirmed that a regular and consistent team of care staff was allocated to each person receiving a service.

The service did not have an electronic monitoring system which would alert them to care staff arriving late to a call or a visit being missed. The registered manager told us that she was reliant on people and relatives letting her know when care staff were late or had not attended to a call. The registered manager explained

that the families of the people receiving care would always call her if the carer was late or had not arrived. The registered manager was able to tell us that there had been one missed visit in the week before this inspection. However, the registered manager did not record details of any missed visits or late calls so that this could be monitored with a view to improving the service.

We asked relatives about whether they felt that there was enough staff available at different times of the day. One relative told us, "They come around at 10-11, 2-3 and at 7. No problems with someone coming around." A second relative commented, "Yes, everything seems ok. There are problems at the weekend. Sometimes every now and again one person doesn't come around. The office will phone us sometimes but most times they just tell the other carer that comes round."

We also asked people relatives about their feedback on care staff timekeeping. One person told us, "Sometimes they are late but this is not a problem." A relative commented, "Happens sometimes they are 20-30 minutes late. Sometimes the office calls me but they are not always late. It is not all the time, just like once a week. We are happy with the service."

Safe recruitment processes were in place to ensure the safe recruitment of staff to work with vulnerable people. Recruitment files looked at contained the necessary documentation including criminal record checks, two references, identity verification documents including bank statements, passports. Evidence was also available of staff member's legality to work in this country. Where a staff member had been working for the agency for more than three years we saw evidence that the agency requested an updated criminal records check as good practice to ensure that the staff members was safe to work with vulnerable people.

All care staff had full access to personal protective equipment at any time when required. We observed that care staff were able to come to the office and collect any supplies that they required.

Requires Improvement

Is the service effective?

Our findings

People and relatives told us that they were confident that the care staff that supported them were adequately trained and skilled. One person when asked about the skills and training of the care staff told us, "Yes, very much so. We are impressed by the combination of professional skills and caring ability." A relative told us, "Yes they are very good. They can use a hoist and all of them are trained for it."

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 checked whether the service was working within the principles of the MCA. During the inspection we found that the service had not completed any mental capacity assessments and there was no recorded information of any best interest decision that had been taken on behalf of the person who lacked capacity especially relating to their care and support. Where the local authority had completed a mental capacity assessment, we saw documents relating to this within the care plan. Mental capacity assessments completed by the local authority were in relation to a person living at an extra care scheme or that a person living with dementia was unable to make any decisions for them self.

Care plans that we looked at, where a person lacked capacity, we found that mental capacity assessments and best interest decisions had not been recorded especially where it had been identified that a person displayed behaviours that were challenging especially when care and support was provided. For one person, it was recorded within the care plan that, "One carer has to hold the hands of the client because they will hit the carer and kick as well." Although the local authority had completed their own mental capacity assessment, there was no mention that a decision had been made in the person's best interest to hold the person's hands and that this was the least restrictive method available whilst supporting the person with personal care.

We looked at the provider's restraint policy which clearly stated that, "If someone does not have capacity then the Mental Capacity Act (and it's Code of Practice) defines a clear process that care services should follow in order to assess and record decisions that are being made on a person's behalf. If it has been clearly defined that someone lacks capacity then the decisions made on their behalf must be clearly defined. This is because it is important that services does not assume someone lacks capacity in all situations as this could result in people being unnecessarily restrained."

The lack of mental capacity assessments was highlighted to the registered manager. The registered manager told us that they had informed the local authority of the issues around behaviour that challenges especially where the care staff were instructed to hold the persons hands. Although the registered manager had a good understanding of the MCA, their belief and understanding was that as long as they had reported the concerns to the local authority, that this was sufficient and it was the responsibility of the local authority

to carry out the necessary assessments and record any subsequent decisions. On the day of the inspection, it was observed that the registered manager was trying to arrange a meeting with the local authority to address this issue.

This was a breach of Regulation 13 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Care staff that we spoke had a good understanding of the MCA and how this impacted on the care and support that they provided to people. One care staff told us, "You still have to ask the person what they would like even if they don't have capacity. It's about knowing the person. If there are any changes I would call the manager and inform. They would inform the OT or the mental health team who would carry out an assessment." Another care staff stated, "The MCA is about including people for example who have dementia. It's about understanding their behaviour. If they lack capacity you can ask their family or next of kin about their needs." Training records that we looked at confirmed that all care staff had received training about the MCA.

We saw evidence that people had signed their care plans consenting to their care. Where people were unable to sign we saw evidence that relatives had been asked to sign the care plan on the person's behalf. Relatives were asked about whether the person was able to consent to care and if they were involved with any decisions made about the person's care needs. One relative told us, "She [person receiving care] will speak to the carers. She [person receiving care] will say something like I want to have a shower now and they will take her." Another relative stated, "Yes definitely." We asked care staff about consent to care and the ways in which they obtained consent from people that they were supporting. One care staff told us, "I always ask them about what they would like and I let them know what I am doing."

All care staff employed received an in-house induction where the registered manager went through all internal processes of the service which included looking at a number of key policies and procedures and the day to day processes of working out in the community. The service then delivered training of mandatory topics which included safeguarding, moving and handling, first aid, and an introduction to dementia. Training certificates showed, and care staff we spoke with confirmed, that they had received this training before they started work. One care staff told us, "Yeah we got an induction, induction is good so you know what you are doing and know about the client and what they need. They give training and at the end there is a qualification. Training starts when you join so you know what to do." Another care staff commented, "The training was very good." Records also confirmed that training for each care staff was refreshed on an annual basis.

Due to the earlier issue we had identified around restraint, when we looked at the restraint policy it clearly stated that all staff should receive basic training on restraint techniques. We highlighted this to the registered manager who confirmed that restraint training had not been provided. On the day of the inspection we pointed out to the registered manager the importance of ensuring that they followed their own policy and that all staff should have received appropriate training to ensure the safety of the person they were supporting as well as ensuring their own safety when delivering care. The registered manager agreed and immediately organised restraint training with an external provider for the following week for all care staff to attend. Care staff we spoke with after the inspection confirmed that they had received the training within two working days of the inspection.

Records showed, and care staff spoken with confirmed, that they received regular supervision with the registered manager. The service had a supervision policy which stipulated that care staff would receive supervision every three months. Records seen confirmed this. One care staff told us, "I have regular

supervisions, the manager is supportive." Another care staff told us, "Yes when they call it could be 6 months we have to go and see her. If she is short staffed she will come out and help us. We work together as a team. Yes, it is effective." Records confirmed that all care staff that had been in employment with the agency for more than a year had received an annual appraisal.

Care plans provided information about people's dietary requirements. For example, where people required a soft diet, information and direction was available for the care staff to follow if they were supporting the person with their nutrition and hydration. Another person required a halaal diet due to religious beliefs and this was recorded within their care plan.

We spoke to relatives about the support people received with their nutrition and hydration. Most relatives supported the person themselves and so there was very little for the care staff to do. However one relative told us, "They give her breakfast, tea or coffee. She [person receiving care] is nourished and happy." We also asked care staff about how they supported people with their meals and whether they were aware of people's dietary requirements. One care staff told us, "I ask them what would you like to eat or drink. By talking to them and explaining what's good or bad for them and why it's better for them to eat something else. Some of our clients only eat fish, some are vegetarians or don't eat ham."

Care plans contained information about people's medical and health care needs. Care staff knew the people they supported well and reported any concerns or changes in people's health to the registered manager and relatives where appropriate. We saw evidence of communication between the registered manager, health and social care professionals where concerns were noted about the care and support a person received including referrals that were made for specific concerns or needs. We asked care staff about how they would support people to manage their healthcare needs. One care staff told us, "By providing good care for them. I would talk to the manager and report it." Another care staff said, "We report any changes to the office. Personal care is not always the main issue. It is food, safety and wellbeing of the person that is also important."

Good

Is the service caring?

Our findings

People and relatives we spoke with were very happy with the care and support that they received from the care staff team. People and relatives told us that care staff were caring, kind and compassionate and treated them with dignity and respect. One person told us, "The care is good, very good." One relative made the comment, "Yes, the way they take [name of person] to the shower or take her anywhere they are very careful and going at her pace. They are also very careful of her catheter and they take time to dress her and make sure she is alright." Another relative commented, "Yes, the ones I've got are really nice and very good. They come in and change his pad, makes sure he doesn't have a rash and cream his body."

Staff understood people's needs with regards to their disabilities, race, sexual orientation and gender and supported them in a caring way. One care staff member said, "You have to respect their individuality in relation to their religion or sexuality. You have to respect people like you would like to be respected yourself." Another care staff member told us, "I would try to do my best to help any person, this is not a personal job." Training records confirmed that staff received training on equality and diversity. One care staff, when asked about the training, told us," Yes done all the training, looking after the client, treating them right and with equal rights. We are there to look after them and make sure they are alright."

Each person receiving a service had a care plan which included information about who they were, their ethnic background, religious beliefs, dietary requirements and a support plan which detailed of all the care and support tasks that were required. Out of the six care plans that we looked at we found that only one care plan contained some background and personal information about the person which included details about their life history. Care plans also lacked an element of being person centred and were more task focused. We brought this to the attention of the registered manager who told us that they would look into this with a view to making improvements.

People and relatives told us that they were involved in the planning and delivery of care at all times. We were also told that the care staff and the management team were always available and listened to them especially when it was about making decisions about their care and support. One person told us, "Communication is fine, there is always someone there and they do listen." One relative confirmed, "They have created a care plan which they follow. This was discussed at the beginning with me." Another relative told us, "They do a lot of little things that are not necessary and they do fuss over her [person receiving care]."

Care staff were very passionate about promoting people's independence. When we asked care staff about this the responses we received included, "We let people do what they can do and help them in the area that they need" and "I try and get people involved, I encourage them to do things themselves and to try and participate."

Relatives were very positive about the care and support that the person related to them received especially in relation to their privacy and dignity being maintained. One relative told us, "One [care staff] will take her to the shower and the other [care staff] will make breakfast. They always close the doors or cover her up."

Another relative when asked about whether the care staff respected the person's privacy and dignity confirmed, "Yes they are very good. I've got exactly what I am looking for."

Care staff gave specific examples of how they would ensure they maintained a person's privacy and dignity at all times. One care staff explained, "I would ask them what they would like before I start. Is there any special way they would like their care. I would ensure that the door was closed when supporting them with personal care. I would ask them whether they would like me to stay in the bathroom. I'd put myself in their place." Another care staff told us, "I would close the door and I would ask people who did not need to be in the same room to leave the room."

Good

Is the service responsive?

Our findings

People and relatives told us that they did not have any complaints or concerns to raise but if they did they knew who they would speak to and were confident that there concerns and issues would be resolved immediately. One person told us, "We know the manager. We are very blunt and will say what we need and if we have any concerns we would inform the manager." One relative gave us an example of the time they had complained and stated, "Don't have any complaints. For example, one of the carers was always on the phone and she was speaking very loudly. I spoke to the manager and she hasn't come back again. I've changed the carer twice now. She is very good at dealing with anything I ask." Another relative commented, "No I don't, never looked into it as I don't have any problems."

The provider had a complaints policy which was given to people and relatives when a service was first commissioned. The policy outlined details on how to raise a complaint and the timeframes in which the complaint would be dealt with by the agency. The service had not received any formal complaints. The registered manager explained, "Clients and family tend to call me directly with any complaints or concerns and I tend to deal with them immediately by visiting them straight away."

The service also held records of all compliments that they received from relatives and health and social care professionals. We looked at the most recent compliments that had been received which included the following comments, "Thank you for the care that you are providing [name of person] Your carers are excellent people and I would like them to be made aware of our appreciation" and "[Name of person] has now made good progress and is mobilising with a frame as far as the door. This is thanks to your very sensitive and knowledgeable carers."

The service carried out an initial assessment before a package of care was agreed and provided. The service recorded the person's individual details, information about their health, any medicine support that was required and completed environmental, health and safety and moving and handling risk assessments so that the agency could confirm whether they would be able to meet the needs of the person. Once service provision was confirmed a copy of the care and support plan was held at the person's own home so that care staff had access to information that was required to provide care and support.

Each care plan was reviewed on a regular basis depending on the needs of the person receiving care. The registered manager explained that as a minimum a new care package would be reviewed within 4 months of it starting. Further reviews after this would be dependent on the needs and requirements of the person they were supporting. We saw evidence of regular reviews taking place and an updated copy of the care plan review was made available at the person's home so that care staff had the most recent information to hand in order to deliver a responsive and safe service.

We spoke to care staff about what they understood by the term 'person centred approach' and how they ensured that they delivered person centred care to the people they supported. One care staff told us, "Person centred care is about dealing with the person individually and caring for them according to how he/she wants it." Another care staff made the statement, "Person centred care is about providing care

around the client. It requires care and compassion." A third care staff stated, "My job is about the person I support. The person is the one I need to be listening to, what they like, what they dislike."

People and relatives confirmed that they received care and support from a regular team of care staff. Rotas that we looked at also confirmed this. Feedback about communication in relation to care staff arriving late or any changes to the team was positive. One person receiving a service lived in a very busy and congested part of central London. The person's relative told us, "I am impressed by the determination and professionalism that the care staff have. They are never more than 20 minutes late which is quite impressive considering our location. They are very good at communicating and as a rule will always let us know."

As part of the care and support a person received, care staff were required to complete daily notes which outlined the level of care and support that was provided and any significant information that was linked to the person in terms of their health or any actions or instructions for the next care staff attending the next call. Recording was consistent and also included the completion of body maps where care staff noticed any bruising or marks on the person whilst supporting them with personal care.

Requires Improvement

Is the service well-led?

Our findings

People and relatives knew who the registered manager was and gave positive feedback about the way in which the service was managed. One person told us, "We see [name of registered manager] and [name of care co-ordinator] on a regular basis. We have had more contact with this agency than any other previous agencies we have used. We have a good relationship with [name of registered manager]." One relative, when asked about the registered manager stated, "She is very good. She comes around and I've met her a few times. If one carer doesn't turn up she will come around if no one else is available to replace her." Another relative commented, "[Name of manager], she is very good. She runs at good ship and she knows exactly what she is doing."

Care staff were also very positive about the registered manager and felt supported in their role. One care staff told us, "We can call [name of registered manager] about anything and she will come quickly to see things and what is going on." Another care staff said, "[Name of registered manager] is very good she would deal with our queries and concerns as and when we report them." However, although feedback from people, relatives and care staff was positive, we found that improvements needed to be made in relation to the overall management of the service.

There were systems in place to monitor and oversee the quality of care that the service provided. This included regular spot checks of the care staff whilst they were at people's homes providing support. The registered manager told us, "I carry out spot checks as often as I can when I am out in the community. This is almost every week. I do checks first thing in the morning and late in the evening. Records that we looked at confirmed this. We also noted that spot checks were completed where specific concerns were noted especially with staff lateness so that improvements could be made in relation to staff arriving late to calls. However, missed visits were not analysed for trends and to make improvements.

Improvements needed to be made to the arrangements for overseeing the safe management of medicines and ensuring that people who lacked capacity received safe care and support as defined under the Mental Capacity Act 2005 (MCA). The service did not carry out any medicine audits and there was a lack of knowledge and understanding on how to ensure people were receiving medicines in a safe way.

We highlighted these issues to the registered manager who told us that she would look into ensuring an improvement plan was put into place to address these issues and make the necessary improvements.

Quality assurance questionnaires were completed on an annual basis from when the person began receiving a service. People and relatives confirmed that they had completed a questionnaire. One relative told us, "They bring in a form 2 or 3 times since we have been here." Responses seen were positive. The registered manager told us that she personally went to visit all the people and relatives to support with completing the questionnaires and if any issues were identified she would try and resolve them as part of the visit. However, any issues identified, an analysis of the results and actions taken were not recorded.

We spoke to relatives about how involved they felt in terms of service provision for the person receiving care

and whether they felt able to make suggestions and whether they felt listened to. Relative's responses were positive and included, "Yes I go to all the meetings. Social services come around once a week and the agency comes around with them once a month. They also say if there any problems just to call them" and "I cannot get out of the house to attend any. But now and again they [the agency] do come round here to have a chat."

The registered manager as well as care staff told us that they visited the office on a weekly basis whereby they could speak with the registered manager who was available to all times. The registered manager also told us that this was her opportunity to speak with them to update them on anything which had relevance to their work and supporting people. The agency did hold care staff meetings with the last one held in January 2016. The agenda included reporting any occurrences with the client, staying beyond working hours, exchanging of schedules.

However, the registered manager told us that it was not always possible to hold staff meetings on a regular basis as care staff would not all be available due to their working patterns and so used their weekly visits to the office as an opportunity to have a chat with them to discuss any matters arising.

The service had a rota management system which was used to plan and organise each staff member's rota. We saw a sample of three rotas and found that the service did not always allocate sufficient travel time between shifts. We highlighted this to the registered manager who told us that the shifts allocated without any travel time were quite close to each other and that care staff adjusted their own timings. We told the registered manager that this may be a reason why care staff were sometimes late to their visits. We asked the registered manager to look into this and ensure that each care staff were allocated sufficient travel time between care shifts.

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 People using the service were at risk because the service did not assess and mitigate individual risks identified as part of the care and support plan. People who use services were not protected against the risks associated with unsafe and improper management of medicines.

Regulated activity	Regulation
Personal care	Regulation 13 HSCA RA Regulations 2014 Safeguarding service users from abuse and improper treatment Where a person lacks mental capacity to make an informed decision, the service did not act in accordance with the requirements of the Mental Capacity Act 2005 and associated code of practice.