Riseup Healthcare Ltd

Dorley House

Inspection report

Norwich Road
Besthorpe
Norfolk
NR17 2LB

Tel: 01953797130

Date of inspection visit:
03 August 2017
07 August 2017

Date of publication:
12 October 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 3 August 2017 and the inspection was announced. We gave the service 48 hours in line with our methodology for domiciliary care services. The agency was registered in 2015 and has not had a ratings inspection since its registration. The service had a registered manager who has since left and the registered provider has applied to be registered manager. Their fit person's interview with the Care Quality Commission was scheduled for the week after the inspection. They have since been successfully registered with the CQC.

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.

The service is registered for personal care. At the time of our inspection there were 40 people using the service. The service is able to provide different levels of support including assistance with personal care, a sitting service and domestic support.

The service had gradually increased the number of people it supports and recently secured a contract with Norfolk County Council. Most people using the service had been referred through the council, a small number of people paid for their care. The recent growth in the service has not compromised the delivery of care but the service is stretched and some concerns were expressed about the timings of calls and hour's staff were working so this needs to be closely monitored.

Staff received training in all key areas of practice. Staff understood what to do to safeguard people from the risk of harm or abuse. People were given information of who to contact should they have any concerns or had experienced potential or actual abuse.

Systems were in place to ensure people's care needs were clearly identified and documented. Staff where required supported people to take their medicines. Staff received training to enable them to do this safely but the manager was not able to demonstrate that all staff had all been assessed as competent to do so.

The service only employed staff after they had completed an interview and demonstrated they had the right skills and attitude for the job. Pre-employment checks were carried out to check their suitability for the role.

The service offered a range of training to staff in key areas of practice. Staff completed a probationary period and were required to undertake an induction course into care, and attend training as relevant. Training was of a high standard but the timing of the training meant some staff new to care were perceived by some people and other staff as not having enough knowledge or experience to deliver the care required. All staff were offered regular face to face supervision, appraisal of their performance and direct observation of their practice.

Staff worked lawfully to ensure people were consenting to the care and support they received and support was provided in line with people's assessed needs.

People's needs were assessed before staff provided a service. Some people required specific support to ensure they were eating and drinking enough and this was documented. If people had specific health care needs this was provided by staff who had the necessary training and guidance.

The service was responsive and staff provided considered, respectful care. They supported people's independence.

The service took into account people's wishes and acted on their feedback. There was an established complaints procedure.

Risks to people's health, safety and welfare were documented but it was not always clear how risks were clearly mitigated or how the service monitored risk. Care plans gave information about people's needs but could be further developed to give more detail to help staff really get to know the person and help them give more person centred care.

People and their relatives' views were sought as part of the service's quality assurance process.The registered manager understood their responsibilities to report specific incidents to the Commission but had not completed a detailed analysis and investigation following an incident. We also found a concern raised had not been recorded as such showing clear outcomes for the person concerned.

There were a number of systems for checking the safety and effectiveness of the service such as regular audits. Staff said they were supported by the management team. However we noted that some areas for improvement we identified had not been addressed by the service and it was not clear going forward how the service decided on what improvements they needed to make in terms of its service delivery.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were adequate measures in place to safeguard people using the service. Clear policies were in place and staff received training.

Risks to people in respect of their health and welfare were documented but we could not clearly see how risks were mitigated.

There were good recruitment processes in place to ensure only suitable staff were employed.

There were systems in place to ensure medicines were administered safely but staff competencies were not thoroughly assessed to ensure they had the necessary skills to do so.

Staffing levels were adequate which meant people got the support they needed in respect of their care and welfare but consideration needed to be given to the timeliness of calls

Is the service effective?

Good

The service was effective.

Staff received adequate training and support but some staff inexperienced in care would benefit from a more detailed induction.

Staff supported people in line with their wishes. Staff understood the basics of the Mental Capacity Act 2005.

People's needs were identified at the point of assessment. Staff supported people with their dietary needs and health care needs if required.

Is the service caring?

Good

The service was caring.

Staff were familiar with people's needs and established positive

working relationships with them.

Staff were reported to be kind and respectful in their care delivery. Support was provided in such a way that respected people's independence. Times of calls were not always in line with people's needs.

People were consulted about their care and care was delivered accordingly.

Is the service responsive?

Requires Improvement

The service was mostly responsive.

People's care and support needs were known by staff and adequately planned for.

Daily notes reflected the care and support people received.

Improvements in record keeping were identified as some care plans failed to specify how a risk should be clearly managed or clearly identify level of need and support required. .

The service was responsive and had an established complaints procedure and acted on people's feedback.

Is the service well-led?

Requires Improvement

The service was mostly well led

This was the first inspection to the service since its registration and we identified some things which required improvement. However we had confidence in the manager to address the issues.

We raised issues around insufficient detail in some care plans which would help staff when providing care. Risk assessments did not always include a clear plan of action to reduce or mitigate risk. The financial policy lacked some important guidance for staff.

Staff competencies in some areas needed to be clearly established through observation of their practice and shadowing.

The manager was respected and staff and people using the service felt they could speak to them and they would address any issues they might have.

The service had systems and processes in place to help ensure it delivered a good service, took into account feedback from people using the service and had a well-trained, competent work force.

People's needs were assessed and the service planned as far as reasonably practicable around people's needs.

Dorley House

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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection took place over a number of dates with a visit to the registered office on 3 August 2017. This visit was announced. We gave the provider 48 hours' notice because we needed to check that the manager was available, we needed them to contact people using the service for us to visit. We carried out some visits to people's homes on 7 August 2017.

We reviewed the information we held about the service including recent notifications which are important events the service is required to tell us about. We spoke and shared information with our registration team who interviewed the manager just after our inspection and registered them with the CQC. We did not receive a provider information return which gives information about this service as this had not been requested.

We reviewed three staffing records, five people's care plans and other records relating to their care and looked at how the service was run.

The inspection was carried out by one inspector. We visited three people and met one person's next of kin. We also spoke with a further three people, two relatives and two health care professionals via telephone. We met and spoke with the manager, deputy manager and two care staff.

Good

Is the service safe?

Our findings

People had confidence in the service and the care staff who delivered their care. Everyone we spoke with said they had been able to contact the office when they needed to and care calls were always delivered. Staff received training on protecting adults from potential or actual abuse. There were clear policies and procedures in place for staff to follow including a flow chart of who to contact if need be. Staff spoken with were clear of what actions they should take if they suspected a person to be at risk of harm or actual abuse. Staff were aware of the importance of record keeping and how to record and store sensitive information. People using the service were provided with essential care information. This included who they could contact if they had any concerns about their care or safeguarding concerns.

There were appropriate arrangements in place for supporting people with their finances however the policy required updating. We noted that staff supported one person with their finances and a financial transaction sheet and receipts were kept. The financial policy for the service was insufficient as it did not cover things staff must not do. For example there was no guidance around store loyalty points or the use of credit cards and we did not find the policy adequately protected people from the risk of financial abuse. We discussed this with the manager who immediately confirmed that this would be added, the policy recirculated and discussed with staff to help ensure people were adequately protected. The policy did cover wills, gifts and gratitude's.

Individual risk assessments were completed before delivering a service but we found information did not always result in a clear plan of action to reduce or mitigate the risk. For example, single pieces of information were provided such as, 'does not have smoke detectors fitted.' There was no further exploration of the possible consequences of this. Equally, individual risks such as,' unsteady of feet,' 'high blood pressure' had not been considered collectively in terms of an increased risk of falls. This meant we could not clearly see how staff were informed about the risk, possible consequences and actions they should take to reduce risk. Staff we spoke with had a good understanding of people's needs and how to mitigate risks associated with people's care. For example we saw that there were good control measures for reducing cross infection. Staff were reporting and recording changes in people's needs and circumstances so that their records could be updated to reflect a change in need.

The service had robust recruitment procedures in place. This helped to ensure only suitable staff were employed. Staff files inspected included staff's employment history, employment and personal references, a disclosure and barring check to ensure the person did not have a criminal record which might make them unsuitable to work in care. Staff files provided information of their address, personal identification and health history. We saw a record of interview notes which demonstrated that robust staff recruitment and selection processes were followed.

We asked people about the service and if it was reliable and received mixed views. One person told us they had not had any missed calls and calls were usually delivered on time. They told us their carer had been fifteen minutes late this morning but that was because another person had fallen. Another person told us, "They are all very efficient and their time keeping is very good."

Staff told us that they had regular calls which were close together to reduce the amount of time they spent travelling. However, they told us this could change and they were sometimes asked to pick up calls which were further away and this resulted in them running late throughout the day. Minimal gaps were seen in staff's rotas which meant they had back to back care calls with little space in between. This could prove problematic if people required a bit more time as the care staff would then run late for the rest of the day. Staff said additional calls had been manageable in the past but one member of staff described things as, "More hectic and a lot busier." Other staff confirmed that sometimes they were in a hurry to get to the next call. Some staff told us that the less experienced staff sometimes felt overwhelmed with the number of calls they had. Staff also told us people were not told in advance about changes to carers which caused them some anxiety.

The service used technology to monitor the delivery of care. Staff had apps on their mobile phones which enabled them to log in and out when arriving at people's homes to deliver care. This helped the manager monitor staff's movement and ensured people received their visits as required. The deputy manager knew the geographical area well and planned care calls in advance. They took into account where staff and people lived to try and reduce travel time. They also took into account people's preferred visit time but operated half an hour either side of the agreed time. People were given their rotas in advance which told them which staff were covering their care call. However, everyone we spoke with said they were not told about changes to their rota so they did not know who to expect. Everyone we spoke with also told us they had lots of different care staff and changes were common at times of staff sickness and holidays.

The manager told us they had not missed any care calls and did try and meet a person's preferred call time. However they said this was sometimes unrealistic. They gave the example of a person who had been scheduled for one visit a day but soon required additional visits. This was discussed with the person and the service told them what times they could provide which was accepted at the time. However at the earliest opportunity they offered the person their preferred call times and said they altered call times to suit the person when they could.

People told us that staff only ran late if they were asked to cover additional calls or were having to respond to a change in need or an emergency. However no one had experienced visits running later than half an hour outside their agreed call times. The manager and deputy manager said they could cover care calls when necessary, and they had staff working a variety of part-time and full time hours who were able to pick up additional shifts. We asked if there was a clear contingency plan to cover care calls should the service have a number of staff sick at once. The manager told us they were about to sign an agreement with another agency who could provide a temporary, emergency backup provision if necessary.

Staff administered medication when this was identified as necessary and care calls took into account any medication which might be time critical and to ensure adequate spacing between medication. The service assessed what support a person required with medication and whether staff should prompt or administer medication. This was documented in the medication risk assessment and care plan. It included details of what medication they were taking, where it was to be stored and who would collect the medication. Medication records were clear and showed staff signatures when it had been administered. We did not identify any gaps on the medication recording sheets. There was a separate recording record for topical medication such as creams and the ones inspected were completed correctly.

Staff received training on the safe administration of medication. However, it was not clear how all staff competencies were assessed when administering medication to ensure they were confident and following the company's policy. Senior staff carried out spot checks on staff regularly throughout the year. This meant staffs practice was observed as they delivered care, which may or may not involve the administration of

medication. Staff new to care also completed a nationally recognised induction which covered medication practices and would require an assessor to sign them off as competent. However we could not see that all staff had been assessed or that there was a rolling programme to do so. We discussed this with the manager who told us that all staff were also going to complete the Norfolk County Council training in relation to medication and they would access competency assessments and ensure this was completed for all staff.

Medication records were transferred back to the office and checked for accuracy and formed the basis of a medication audit but this in itself was insufficient in terms of identifying medication errors in a timely way. Improvements were required in the way the service audited medication records and supported its staff to ensure they were sufficiently competent. However we were confident that the manager had taken on board the improvements required.

Good

Is the service effective?

Our findings

Staff had the necessary competencies and skills required to do their jobs but improvements in the way this was evidenced is required. Once in employment staff underwent necessary training, induction and shadowed more experienced members of staff. We saw staff training records and these were comprehensive and showed a mixture of face to face training and e-learning for updates. Staff who had not worked in care before completed the care certificate, which is a nationally recognised induction to care which covers all the essential elements of care. The providers training log showed dates of when staff completed their training and highlighted in amber when training was due or red if it had expired. This tracker enabled the manager to plan refresher training in a timely way to ensure a competent workforce. Training available to staff was bespoke around the individual needs of people they were supporting and took into account long term conditions people might have to ensure staff were confident when delivering care and had sufficient knowledge.

One person told us that not all carers were confident in what they were doing or received all the necessary training before being able to provide care. They said, "They are shadowed but only for one shift. They need longer." We explored the induction process and saw that staff received on the job training throughout their induction. However induction records were not sufficiently robust because they did not clearly highlight what staff were doing well or where they might require additional support, guidance or further training. Staff induction was a mixture of training, practical on the job support and shadowing more experienced staff. The length of time a staff member shadowed a more experienced member of staff for was based on their previous experience and confidence. The manager said staff could be on shadow shifts anything from a day to a week. We were not assured that that all staff had sufficient opportunity to work alongside others for long enough. Staffing rotas showed us when staff were on shadow shifts. A new member of staff had one day of shadowing. but were very experienced in care. Another had six shadow shifts but this was not reflected in their shadowing induction/checklist. We were unable to see clearly what had been observed as part of staff's induction. The manager told us they had constant contact with staff and felt they would quickly identify if a staff member was struggling and they received feedback from other, more experienced staff. However the service would benefit from improving their induction records to clearly show what support is provided to new employees. Records should demonstrate how staff were meeting the expectations of their job role within the twelve week probationary period.

We spoke with staff who confirmed that they had completed training for all areas of health and social care such as manual handling, infection control, first aid and safeguarding and this was refreshed as required. They went on to say they completed training when it became available so was not always completed within the probationary period. They confirmed they had spot checks of their performance, supervisions and a probationary period.

The manager told us they met regularly with Norfolk County Council and were able to access the training they provided. They said it was their intention to access the counties medication training. This was in depth and in line with their medication policy, which reflected national and local guidance. The current medication training provided to staff fell short of expected standards as it did not clearly show how staffs

competence was regularly reviewed.

Most staff had been employed for less than a year but the provider's intention was to hold a yearly appraisal for all staff. Staff had regular face to face supervisions and quarterly spot checks of their practice, when delivering care in people's homes. People confirmed this. Staff also told us there was a good network of support so they could benefit from the experience of other staff and work as a team.

Care tasks were identified following an assessment of the person's needs which sometimes included supporting people with their meals and drinks. Specific food and fluid records were not seen but staff kept detailed notes showing what care and support they had provided which included support to eat and drink. Food and fluid charts were kept where a concern had been raised but the manager said they did not routinely contact the speech and language team or dietician but would refer concerns to a family member or social worker. The service worked closely with family and other health care professionals to ensure they understood and have the skills and confidence to meet people's assessed needs. Specific training would be provided around individual's health care needs. For example, if staff supported people living with dementia and supported people with end of life care.

The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process.

Staff worked lawfully to support people in terms of consent which was sought before any care task was undertaken. We found that people were consulted about their day to day care and involved in the assessment, planning and review of their care. Staff completed basic training in the application and principles of the Mental Capacity Act but this was not in depth. The manager told us everyone was able to make their own decisions but we were concerned that the service were supporting people with cognitive impairments who could have fluctuating capacity. Care plans viewed did not give details of relatives who held enduring power of attorney for care and welfare and this information should be sought. The manager knew that they should hold best interest meetings where a person's capacity was in question and said they worked closely with social workers to ensure people's choices were upheld.

Good

Is the service caring?

Our findings

The manager spoke passionately about their service and how they had worked in care for many years. They have a strong family ethos and said they had worked hard to develop good working relationships with the staff and other professionals. She felt that staff had developed relationships with the people they supported and there was continuity of care to ensure this happened. Staff saw their role as supporting not only the person who had been identified as having a care need, but their next of kin and extended family. They said that people had a team of regular carers rather than just one or two staff and this had worked well. They employed a relatively small team of staff who were responsible for a small geographical area. Most care staff had considerable experience and were knowledgeable about people's needs.

Every person we spoke with using the service and their relatives said they were happy to date with the service and without exception the carers that supported them. All felt confident that if they were not happy with any aspect of their care they could raise this.

One family told us about the detailed assessment that had been carried out before a service was offered. The family said the manager spoke directly to their relative about what care they thought they needed. They said the manager demonstrated genuine warmth and empathy and they had not been disappointed by the care that has since been provided. They said that staff were quick to raise any issues or changes in need and worked inclusively. They described the agency as, "Phenomenal," and said it had exceeded all their expectations. They told us the carers were, "Exceptional."

Several people told us that when the agency was set up it offered a small, personal service. Some people had transferred from another service which had closed and they said their experiences had been good. They told us they would recommend the service to others. The only concern they had was fears for the future as the service was taking on new work. People described how staff had more visits than before and how they were working long hours and getting tired. This was echoed by staff. One person told us that carers were rushing and they said they did not want this. They wanted, "Calm people." They said, "They are not always relaxed and run to the car." They said care staff did not always get sufficient travel time. However, everyone said they felt the service was well managed and staff were kind, reliable and promoted their independence.

People said staff were respectful and upheld their dignity and confidentiality. They said that staff did not speak about other people but would explain if and why they were running late and consult with them about their needs. People felt consulted about their care and said they had opportunity to talk to staff and the manager if they wanted any changes to their care. This meant the service took into account the wishes and preferences of people which was recorded in their care plans.

Requires Improvement

Is the service responsive?

Our findings

We spoke with people about their experiences of care. One person told us, "This is by far the best company I have had; I have needed care for 11 years." They told us, "I have lots of different carers but they are all good." Another said, "My timetable is constantly changing and they swap my carers about all the time." They said they had about five different carers each week. They said they could not fault the service but would like greater continuity. Although the manager told us everyone's care plan was reviewed within the first six months this was not the experience of everyone we spoke with. Several people could not remember having a review or said this had only been done in the last few days ahead of our visit to them. However the manager said in between the six monthly reviews regular contact was maintained with the person using the service and the family members. People confirmed they had regular contact with the service

People had a detailed assessment before the service commenced. Where the referral had come from the local authority an assessment was available and the service completed their own to ensure they were able to meet the person's needs. The service kept people's needs under review so they could identify any changes to the persons needs and, or circumstances. Care plans were put in situ within 48 hours of support starting. Staff confirmed when carrying out their first initial visit they would have enough information about the person prior to their visit.

Relevant, personal information could be downloaded on staff's phones about their visit schedule and basic details/tasks about each person they were visiting. More confidential data such as key safe codes was sent to staff separately and in a safe format to protect people's confidentiality and personal information. The system had clear benefits for people, and management in terms of monitoring the service to ensure people received their visits on time as far as reasonably possible and staff stayed for the time agreed. It also helped to ensure staff were kept safe as the manager was able to see where staff were throughout the day. The manager said the only drawback could be poor connectivity at times which meant information was not always received straight away. Staff could send information via their phone to the main computer in the office but always recorded their visit in the paper log in people's homes. These paper logs were transferred to the office monthly and reviewed to ensure care was recorded and being delivered appropriately.

We reviewed a number of care/support plans and discussed these with the manager and deputy manager. Some care/support plans were in more depth than others depending on the level of support required and the task to be completed. There were copies of assessments but these provided limited information sometimes just yes or no which might suffice where people had less complex needs. However, we identified a number of people who were at risk of injury due to multiple factors relating to their age, cognitive ability and underlying illnesses. These factors had been identified but there was no clear plan for staff to follow to help reduce the risk to the person. Information was fairly generic i.e. 'assist to toilet' without specifying clearly what the person needed support with or providing specific information to staff such as what their balance and posture was like which would assist staff to provide care and support more effectively. Plans identified areas of concern i.e., person has 'dry skin', 'swollen ankles' but lacked information about how this should be addressed and monitored to ensure the persons health care needs were met.

We identified a person who had a reoccurring fall but could not see what actions were taken to help minimise further risk and were not confident that people's needs were reviewed as often as necessary or that the initial assessments were sufficiently robust. However, we saw that as the service developed care plans had become more detailed. We also spoke with family members who told us they had been involved in the assessment and planning and were happy with the care plans. One relative told us the assessment was very detailed and they were confident that staff were familiar with their relatives needs and communicated any changes to their needs. We also found daily notes kept by care staff went into sufficient detail and clearly showed how they were meeting people's needs.

Staff told us the level of detail in care plans had improved as time had gone on and said they always had enough information before being expected to provide care, or support to someone. Staff said senior staff and the manager were knowledgeable and there was always someone to refer to if they were unsure.

There was a clear complaints policy and procedure and everyone we spoke with felt able to raise concerns. One person said, "Everyone works to a high standard, I am confident to raise concerns, they are easily contactable and have never had any trouble approaching them. " They said they were able to contact the manager if they wished and were confident that things would be acted upon. No complaints were recorded but we did see examples of how feedback was responded to. This showed the manager was responsive. We had concerns raised directly with us in terms of the care a person had received. Their concerns were noted in their daily notes but we could not see how these had been responded to. A meeting had been held but the outcome of this meeting had not been recorded and we could not see how the service had tried to manage this persons concern. The service told us they had not raised a formal complaint, however their concerns should have been responded to as if it were a complaint.

Requires Improvement

Is the service well-led?

Our findings

Since our inspection, the manager has attended a fit person's interview and has been successful with their registration with CQC. As a condition of a provider's registration it is a requirement to have a registered manager. Prior to their interview, we spoke with the manager about her relevant experience and current study which included a level five diploma in health and social care. Some areas of their knowledge were lacking and support and guidance was provided as part of this inspection and as part of the registration interview. The manager was supported by an experienced deputy manager and we were assured as the business grows the organisational structure would be revised. This was to ensure there would be sufficient management oversight and supervision of care staff. We were concerned that at times there was insufficient managerial cover. The manager sometimes covered care calls and the office was not always staffed. Calls were diverted to a mobile phone they carried but this is unacceptable to deliver care and be speaking on the phone. People using the service told us care staff were very good at not answering their phones whilst supporting people but said the manager sometimes did. The manager said that as the numbers of people supported grow, they would have full time office staff and seniors for each team which was split according to geographical location. Currently the service was covering a small geographical area where staff were located and could travel to without undue delays.

People were happy with the management of the service. One person told us the manager was rushed. Everyone else told us, that the manager was very helpful, approachable and people felt able to raise concerns.

Staff spoken with said the manager was approachable and knew everyone they were supporting well and was often out providing direct care to people as well as carrying out assessments and reviews. Staff said it was a family business and there was regular contact between the manager and staff. From the feedback we received we were told the service was sometimes stretched and both care staff and people using the service felt it could affect their care and in particular changes in care staff not being effectively communicated to the person.

Staff reported they received good training and the staff we spoke with were suitably qualified and told us they were well supported. Regular support and contact was provided to staff and staff had team meetings so they could mutually support each other and share good practice. Spot checks on staffs practice were seen and although taking place regularly were not very detailed. For example, they recorded observation of staff and discussion with person receiving the care and support. Areas were ticked as met or comments made where improvements were necessary. For example, one spot check said improvements in medication required. It did not show what was observed or the improvement necessary or what actions needed to be carried out to ensure improvements were made. The manager was able to tell us what the issues were but these had not been recorded. This was therefore an incomplete record. Another example of poor record keeping was in relation to a person who had an accident. The service had notified the CQC as required and completed the necessary paperwork. The person's needs had not been assessed in line with the accident because they were in hospital but the service intended to reassess their needs and rewrite care plans and risk assessments where necessary. However when we reviewed the existing paperwork, risk had been

identified but there was no follow up action or instruction to staff about what they should do to reduce the risk of falls to the person despite a previous fall and some obvious risk factors. The records were incomplete and meant we were not assured this persons needs were being fully met in line with increased risk due to the advancement of old age and physical frailty. This was discussed with the manager and we asked her to clearly show how they reviewed accidents, incidents and near misses to ensure lessons learnt and findings shared with staff.

Policies were in place and routinely updated. However, we asked the manager to update the financial policy to ensure it had all the necessary information. The statement of purpose did not include details of staff employed and their qualifications and had not been updated since the previous manager left. The manager said on receipt of their registration they would update this.

Although we found the manager responsive at our inspection and keen to provide high standards of care we were made aware of a concern which had not been well managed. A person using the service had been unhappy about call times. They had been offered alternative call times and a meeting set up with the local authority to review their care package. However the service had not recorded the person's original concerns or shown how they had tried to meet and facilitate this persons needs according to their wishes. The care placement broke down. The person had only used the service for a short while. The service provided to them fell short of their expectations and the service were not able to be sufficiently flexible in terms of timings of calls which meant the person was left with unacceptable gaps without any care. We asked the service to ensure that where concerns were expressed about the service this is documented to show actions taken even when it's not considered to be a formal complaint.

The service had asked for feedback from people using the service through regular reviews of people's care and support. The manager had also circulated surveys asking people and their relatives view on the service provided. We viewed the surveys returned. The last being circulated on 18 April 2017, 15 surveys were sent out and 11 returned. The service has doubled in size since then. The outcome showed most people were happy with the service they received and where issues were identified the service showed what actions they had taken. However the information from the surveys and there results had not been shared with people using the service. We suggested this should be communicated with people using the service and it would be helpful to see feedback from other stakeholders. Feedback from staff was also not collectively collated which again we felt might be beneficial in informing management about the current picture of the service. We noted that there was no action plan resulting from audits or feedback which would record actions to be taken to improve the service. We identified a number of areas which could be improved upon and were confident that the manager took our suggestions on board.

We spoke with people, relatives and health care professionals and everyone felt a good service was provided. However, concerns were expressed about the number of care staff people could have and call times not always running to time. Most people felt the service did well to meet their needs but one person expressed concerns about being rushed and another expressed concerns about the well- being of care staff. Concern was expressed about the growth of the service and the possible affect this might have on the provision of care.