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Surecare Enfield

Inspection report

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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?	**Good**

Summary of findings

Overall summary

This inspection took place on 19 and 20 July 2016. This was an announced inspection and the provider was given 48 hours' notice. This was to ensure that someone would be available at the office to provide us with the necessary information. When we last inspected this service on 19 December 2013 we found the service met all the regulations we looked at.

SureCare Enfield is a domiciliary care agency based in North London which provides home based care for adults primarily living in the London Boroughs of Enfield and Haringey. At the time of the inspection, there were 139 people using the service. The service provides approximately 4000 hours of care per week and many people who use the service require palliative care. The service employs 115 staff.

The service has a 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.

Risks were not always adequately assessed for people using the service. During the inspection we identified particular risks to people, for example epilepsy and choking which had not been identified by the provider. General risk assessments were in place and were reviewed regularly.

Medicines were not always safely managed. There were inconsistencies between what care plans and medicines risk assessments stated as to what medicines support people received. Daily records completed by staff in relation to medicines support people received differed from what instructions were given as part of the care plan.

The provider did not always adhere to the Mental Capacity Act 2005 (MCA 2005). Some consent forms were signed by relatives with no documented authority. There were no best interest decisions or mental capacity assessments highlighting that people did not have capacity to sign their care plan consent forms. Staff had not received training in the MCA 2005.

People and relatives told us they felt safe. Procedures and policies relating to safeguarding people from harm were in place and accessible to staff. Staff demonstrated an understanding of the types of abuse to look out for and how to raise safeguarding concerns.

The service maintained sufficient staffing levels and people told us that carers generally arrived on time and they were contacted if there were any changes to their care routine.

We saw evidence of a comprehensive staff induction and on-going training programme. However, not all staff training had been updated recently. Staff were safely recruited with necessary pre-employment checks carried out. Staff received regular supervisions and annual appraisals.

We received positive feedback from people and relatives who told us staff were caring, consistent and responsive to their needs.

People were confident about how to complain and complaints were logged. However, complaints were not analysed for trends or learning points identified.

The registered manager had recently implemented a number of changes to improve the care people received and ensure quality was monitored effectively.

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. Individual risks to people were not always assessed

Medicines were not always managed in accordance with the person's care plan. The service has recently implemented a new MAR chart template.

There were sufficient staff to ensure that people's needs were met. There was a robust recruitment procedure in place.

Staff were aware of different types of abuse and what steps they would take if they had safeguarding concerns.

Is the service effective?

Requires Improvement

The service was not always effective. Staff had access to regular supervision and appraisals which supported them to carry out their role. However, some staff had not received recent mandatory training.

Most people gave their consent for their care and support. However, there was a lack of records relating to the legal arrangements in relation to decision making. Staff had not received training in MCA.

People were given the assistance they required to access healthcare services and maintain good health.

People who were supported to eat and drink told us they had no concerns. Staff who supported people with a specialised feeding regime had received appropriate training.

Is the service caring?

Good

The service was caring. People and relatives spoke positively about staff. People were treated with dignity and respect.

Care plans were detailed and provided information about people's needs, likes and dislikes.

Is the service responsive?

Good

The service was responsive. Care plans were person centred and regularly reviewed.

People's needs and wishes from the service were assessed and support was planned in line with their needs.

People using the service told us they would speak to staff if they were not happy with any aspect of the care and support they received.

Is the service well-led?

Good

The service was well led. The quality of the service was monitored. The registered manager had recently implemented a number of improvements in how the service was quality assessed.

People, relatives and staff spoke positively of the registered manager.

Surecare Enfield

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 provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.

This inspection was carried out by one inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience supported this inspection by carrying out telephone calls to people who used the service and their relatives.

Before the inspection we reviewed the information we already held about the service. The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed notifications, and safeguarding alerts. We also spoke with local authority commissioning and adult safeguarding team and one health care professional.

During the inspection we reviewed 12 people's records including care plans and risk assessments. We also looked at 13 staff files and training records and other documents related to the running of the service.

As part of this inspection, we visited two people who use the service. We spoke with 11 people using the service and 10 relatives. We also spoke with the director, the registered manager, deputy manager, a deputy coordinator, a care coordinator, two field supervisors, a recruitment officer and five care workers.

Requires Improvement

Is the service safe?

Our findings

Care files contained risk assessments which addressed generic areas of risk such as environmental risks, manual handling and medicines, where relevant. Risk assessments were reviewed on a yearly basis and records confirmed this. However, we found risk assessments had not been carried out specific to the individual needs of some people using the service. All risk assessments contained a section called 'Control measure action to be taken to minimise risk'. In all moving and handling risk assessments viewed during the inspection, the information contained within this section was that all carers were fully trained in manual handling and must follow correct procedure. The registered manager told us that staff received moving and handling training on a yearly basis, however on review of staff training records, we found that 16 staff members last had moving and handling more than one year ago with two staff members last having moving and handling training in 2014. This meant that the people were placed at risk of injury during the moving and handling as not all staff had recent training in this area.

We identified risks to people such as choking, skin integrity, mobility and falls, epilepsy, dysphagia and the risks associated with the use of a Percutaneous Endoscopic Gastrostomy (PEG) feeding regime. Risk assessments were not completed to demonstrate the appropriate management of these risks in order to minimise them leading to serious health complications. This placed people at risk of harm as risk assessments failed to provide enough information for staff to adequately understand or mitigate risks posed to people they cared for.

During the inspection, we visited one person whose relative told us that they had a pressure sore "a few months ago." On review of this persons care file, we found that the person's risk assessment and care plan which had been completed in September 2015 had not been reviewed or updated to address the person's pressure sore. This meant that people were not always protected from risks and action had not always been taken to prevent the risk of harm.

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

We looked at the arrangements in place to ensure people would receive their medicines safely when needed. A relative told us, "My mother only really has a carer going in to encourage her to eat each day and to ensure she takes her medication. If she were left on her own, she wouldn't take her tablets and she'd hardly eat at all. Her carer gets the tablets from the dossette box and actually watches her taking them before writing in the records."

The registered manager told us that staff received medicines training on a yearly basis. However, on review of staff training records, we identified that two staff last received medicines training in 2012, seven staff last received medicines training in 2013 and five staff last received medicines training in 2014. This was addressed with the registered manager who advised that following the inspection, additional medicines training sessions would be arranged to ensure all staff medicines training was within date.

Care plans contained a medicines assessment which noted if people required assistance with medicines, whether it was full support, prompting or no assistance required. Where people required full assistance or prompting, prescribed medicines were listed. The registered manager told us that a new style Medicines Administration Record (MAR) was created on the week prior to the inspection, as it was recognised that the MAR in use was not fit for purpose. The registered manager told us that they were rolling out the new MAR and expected it to be completed within one month.

During the inspection we looked at the older style MAR charts in place for people who were supported to take medicines. Where medicines were administered from a blister pack, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. MAR charts are the formal record of administration of medicine within the care setting. We saw one instance where the staff member administering the medicine recorded that they had supported the person to take seven tablets every morning, however the medicines list in place for the person in their care plan stated that the person took six tablets every morning. We discussed this with the registered manager who advised that she would look into the matter.

Staff were not always consistently recording what support they were providing to people being supported to take medicines. For example, we looked at one persons MAR chart and noted that some staff were recording that they were prompting the person to take their medicines and other care staff were recording that they were administering the medicine to the person despite the persons care plan stating that staff were supposed to administer medicines to the person.

The registered manager had recently implemented a competency assessment for the safe administration of medicines. This check assessed whether the staff member was appropriately trained, whether they obtained consent from the person they were supporting to take medicines and whether they were competent to administer the medicines. On review of staff files, we saw that one staff member out of 13 had been assessed. The registered manager told us that prior to the implementation of the new medicines assessment, MAR charts were checked on a monthly basis by a care coordinator when they were returned to the office. If issues were discovered, the carer was called to discuss this. However, this was not recorded and concerns or errors noted were not logged or analysed for trends.

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

People told us they felt safe. One person told us, "To be honest, I don't think I would be able to have a shower here on my own anymore because I am just too unstable on my feet. The carer being here gives me the confidence that if I do feel faint and wobbly, there will at least be somebody here to help me. It is so important to me I can stay here at home that it is worth it to have a carer here just to give me that confidence." A relative told us, "My mother loves her carers to bits and she would be very distraught if any of them left the agency. I tried to tell her that unfortunately people don't stay in this line of work for very long so that she can prepare herself for the day when they do leave but they are really like members of the family now."

A health and social care professional told us that the service was safe and if the service was unable to fulfil a care package, they would inform the local authority of the fact.

People were supported with sufficient staff with the right skills and knowledge to meet their individual needs and promote person centred care. One person told us, "My one carer is perfectly capable of doing everything that I need so I don't have any problems with not having sufficient help." A relative told us, "My husband has

two carers who come because he has to be hosted from the bed to the commode and then to his wheelchair and this happens three times a day. They are very good with him, but he definitely needs both carers here all the time."

We looked at 13 staff records in order to ensure that the service had undertaken safe recruitment checks for each person that it employed. Staff files included application forms, records of interview and appropriate references. However, in one instance, we saw that a member of staff who had declared previous employment as a carer but did not declare the previous employer as a referee. This was not followed up during the recruitment process. Instead the service obtained two references from other former employers not in the care sector. This was discussed with the recruitment administrator and registered manager who confirmed that they would follow up this with the staff member in question and obtain the appropriate referee contact details. However, we saw on another staff file where it was established that a professional reference was also a family friend; a risk assessment had been completed and the member of staff was asked to provide another referee to ensure completeness of the reference process. Records showed that checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults and children. Records confirmed that staff members were entitled to work in the UK.

People told us that they did not experience late or missed calls on a regular basis. "My carers will usually arrive on time or thereabouts. If they are running any more than about 20 minutes late someone from the office will usually call me. I have had one totally missed call, when my regular carer was off on holiday, when I phoned the office to find out why someone hadn't turned up, they told me that they had asked a different carer to come and cover the holiday period but she had thought it was the following week. The office asked if they could organise to send somebody to me a bit later on that morning so I waited and had my shower later on. The office were very sorry about the mix-up and it hasn't happened again." Another person told us, "When my three regular carers are working, there is not usually a problem and I know if they get held up with the previous client they will usually try and ring me. A couple of months ago when one of my carers was off sick; nobody came to sort my breakfast out. I phoned the office and they told me that they had organised someone else to come, but that she had got confused about the date. Thankfully my daughter had popped in that morning and was able to organise my breakfast so I told them on this occasion that it was alright, they didn't need to find somebody else to come. It hasn't happened since."

The registered manager told us that they do not at present monitor missed or late calls electronically and people are encouraged to call the office to report late or missed calls. We discussed with the registered manager how people who may be unable to call the office to report late or missed calls are monitored. The registered manager told us that due to the nature of their service which is mostly palliative care with family present and most visits require two carers to attend, late or missed calls are rare with minimal impact on the people who use the service. The registered manager told us that the service is good at picking up late or missed calls.

Staff told us that they had adequate travel time between visiting people and if they were running late they would contact the person and the office. One staff member told us, "I travel by bus. I have enough time and I make sure I call them. Sometimes I would like to have more travel time." We looked at the rota management system and spoke with a deputy care coordinator. Travel time was factored between calls which was linked to a map application which gave the service the estimated travel time between visits. However, we saw one instance of five minutes being allocated to a carer to travel between visits when the map application estimated that the driving distance between the visits was eight minutes. We also saw that on the day of the inspection, the deputy co-ordinator was rostering afternoon visits for people who at that point did not have carers allocated. We saw that late calls were recorded on a spreadsheet and the deputy coordinator told us

that the main reason for missed or late calls usually down to mis-communication or the carer not correctly reading their rota.

Accidents and incidents were recorded, however actions, outcomes and learning from accidents and incidents was not always identified. This was discussed with the registered manager who told us that a new accident and incident monitoring form was recently developed and was in place in every person's home for care staff to complete as and when an incident or accident occurred. This was confirmed during visits to people's homes.

Staff understood how to keep people safe and their responsibilities for reporting accidents, incidents or concerns. One member of staff told us, "It is regarding how to protect people, money, privacy and how to look after them. If I have concerns I would inform the manager and take it from there. I have done online training and can report to the social worker and if extreme, the police." Another member of staff told us, "If I had concerns I would raise it with the registered manager. I would look for changes to eating, moods, communication, financial, physical and changes to regular habits."

The provider had a safeguarding policy in place which staff had access to. Safeguarding referrals were logged and followed up with the relevant local authority; however, the registered manager had not informed the CQC of two safeguarding referrals made to the local authority. This was discussed with the registered manager who explained it was an oversight and advised that the relevant notifications would be sent to CQC. Staff were scheduled to have safeguarding training on a yearly basis, however, training records showed that some staff last had safeguarding training in 2012, 2013, 2014 and early 2015. This was discussed with the registered manager.

The provider had a whistleblowing policy and staff had a good awareness of whistleblowing. One staff member told us, "If I find out that procedures are not being followed or there is poor conduct which is not followed up. I can contact the CQC."

Requires Improvement

Is the service effective?

Our findings

People and their relatives spoke positively about staff and told us they were skilled to meet their needs. One person told us, "As far as I'm concerned they are all very good and we just get on with things whilst having a bit of a friendly chat." Another person told us, "My carers have been coming for so long now that I know them really well and they know me. When someone new does come they will usually have a look at my care plan and I will talk through what it is I need help with. There has never really been a problem."

All new staff received an induction which consisted of attending training in the office and a period of supervision. Newly recruited staff were also assigned to work with a more experienced colleague on double visits. The recruitment officer told us that it may be many weeks or months before new staff were assigned to visit people on their own and this was following a competency check and a sign off. This was also confirmed by newly recruited member of staff we spoke to who told us, "I have been partnered with someone experienced and I spent a few days watching what she was doing. Some girls have been here months and are still not working alone." Another staff member told us, "They don't send new people alone."

All staff had an individual training record on file which stated the training courses undertaken and the dates of completion. We looked at the training records for a sample of 13 members of staff. Records confirmed that most staff had received regular training in areas such as equality and diversity, food safety, health and safety, medicines administration, dementia awareness and infection control. The registered manager told us that at present mandatory staff training is completed online, which staff can access using a password and complete in their own time. The registered manager told us that they are moving away from online training to classroom training. This was reiterated when we spoke with a member of staff about training who told us, "I don't think online training is good enough. It is not engaging."

Records showed that staff received training in other areas such as PEG feeding, mouth care, end of life care and epilepsy management to enable them to assist people with specialist care needs. However, on review of the overall staff training matrix, we saw that 17 members of staff had not received any mandatory training since 2012, 2013, 2014 and early 2015. This lack of training affected staff skills experience and may have prevented staff from supporting people effectively.
We discussed this with the registered manager who told us that they would ensure that staff training would be brought up to date and following the inspection the registered manager provided evidence that training had been booked for staff.

Staff told us they had regular spot checks, supervisions and a yearly appraisal. Records viewed during the inspection confirmed that supervisions occurred on a quarterly basis with a yearly appraisal for people who had been working with the service for more than one year. As part of the yearly appraisal, a development and training plan was produced. We saw that staff were encouraged to complete professional study and the registered manager told us that approximately 50 per cent of staff were currently undertaking a fully funded NVQ level two or level three.

When asked if staff obtained consent, one person told us, "My carers have been coming for a long while so

they will usually just ask me if I'm ready to make a start when I see them in the morning." Whereas, another person told us, "I think that myself and the carer just get on with things when she arrives in the morning, it just sort of happens."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do 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. People can only be deprived of their liberty to receive care and treatment when this is in the best interests and legally authorised under the MCA. The application procedures for this in community services are to be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

Care plans contained consent forms which were mostly signed by the people who used the service. However we found instances where consent forms were signed by relatives. Care files did not contain details as to why the person receiving care had not signed their care plan. Consent forms did not note whether this was a best interest's decision. A best interest's decision is made on someone's behalf where they are unable to make decisions for themselves. Consent forms did not indicate whether the relative who signed their consent form had a power of attorney (POA) giving them the legal authority to act on the person's behalf. A POA is someone who is nominated to make decisions on a person's behalf where they are unable to do so. It is important to be aware when a POA is in place so that decisions are made by the right person. This information is essential to ensure that decisions made on behalf of people are lawful. This was discussed with the registered manager who told us that the service does not generally complete best interest's assessments.

Records showed that MCA was not a mandatory training subject for all staff and this was confirmed by the registered manager who told us that MCA training would be implemented for all staff and training sessions were booked.

This was in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some people told us that they were supported to access health services. However, many people and relatives we spoke to did not require assistance from the provider to access healthcare services as domiciliary care agencies do not generally support people with healthcare appointments as they provide care such as washing, dressing, medication and food preparation. A relative told us, "My mum's carers arrived one morning to find her on the floor where she had fallen. They immediately phoned the ambulance and then called me so that I could meet the ambulance at the hospital. They were very good with mum because they managed to calm her and make sure that she wasn't too distressed by the time she got to hospital."

When asked how staff supported them with eating and drinking, comments from people included, "My appetite isn't brilliant these days but I do like a nice breakfast so my carer comes for an hour and when I have had a wash she will make me a cooked breakfast every day which I really enjoy," and "My carers will always make sure I have a hot drink and then something cold that I can get at between their visits and they always tell me how important it is that I keep up my drinking. It can be difficult at times because as you get older you just don't feel like drinking as much."

Good

Is the service caring?

Our findings

People we spoke with were very complimentary about their carers with most having a small number of regular carers. Carers were described as dedicated, professional and willing to do extra jobs where these were seen to be necessary for the well-being of the people using the service. One person told us, "My carers are very good, I am 99 this year and they come and help me have a little walk outside every day. I know I can't go far, or very fast but it makes such a difference still to get a bit of fresh air and they are very patient and will just walk alongside me whilst we have a chat." Another person told us, "It can't be easy being a carer, but the two or three that I regularly see are very good and they always make sure that the cream they have to apply to the back of my legs is well rubbed in before they help me dress because it can be very sticky and then I end up in a right mess." A person we visited during the inspection told us, "Everything [my carer] does, she does very well. She always asks me what do you want me to do."

Staff spoke fondly of the people they provided care for and commented that they had regular long term clients. One member of staff told us, "I get on well with people and I am confident in what I am doing. The most important thing is when leaving is making sure the client is happy." Another member of staff told us of an occasion where they supported a person to become more independent. They told us, "I used to see a man who wasn't walking. I kept telling him you can walk. Bit by bit I supported him to walk. His wife was so excited and pleased. It's the little things like that, which matter."

We reviewed compliments received from people and relatives who use the service which included a number of thank you cards from relatives of people who had recently passed away. Comments on the cards made reference to the bonds between the carers and the person who used the service and the caring attitude of the carers who were individually named.

People told us staff respected their privacy and dignity. One person told us, "My carer will never open the curtains in the morning until we've done absolutely everything in the bedroom and I'm fully dressed and the room is tidy again." People also told us that their preferences as regards having male or female carers were noted. One person told us, "I was certainly asked what time of day I would like the calls to happen and also if I would prefer female carers or if I wasn't too worried." Staff demonstrated an understanding of how to protect people's dignity and privacy and could give examples of ways they ensured this happened, for example, closing doors and curtains and covering exposed areas of skin.

Care plans included background information and medical history about the person. People told us they were involved in the planning of their care. A relative told us, "We met with a manager before we started having care from the agency and she sat down and just talked to us about what my husband needed help with. She then asked us what time we would like the carers to visit and whether my husband prefers male or female carers. She then went away and put together what I think is called the care plan and sent it to us to read. There are a couple of things that she got slightly wrong so we phoned and let her know and she then sent it back once it had been altered." This was also confirmed on review of care plans where we saw corrections made to care plans by people and relatives which were then finalised.

The provider had an equality and diversity policy in place and records confirmed that staff had received training around equality and diversity. Staff confirmed that they adhered to people's preferred customs when entering their homes such as removing their shoes or wearing shoe covers, when necessary. During the inspection, we spoke with staff about supporting people with protected characteristics, such as people who identified as lesbian, gay, bi-sexual or transgender (LGBT). One staff member told us, "I remember that everyone is individual and different and treat them for their needs."

Good

Is the service responsive?

Our findings

People and relatives told us they received personalised care which was responsive to their needs. One person told us, "Because one of the managers will sometimes do some of the shifts particularly when my regular carers are away, she will usually pick up if she thinks my needs have changed a bit and then she will meet with me and my daughter to see what we can do about getting some extra help." Another person told us, "The only time that my care needs have changed was when I was having a review with a manager and she realised that from what I was telling her I was struggling a bit more to make myself meals so I now have somebody come and help me with that once-a-day." A health care professional told us the service is very proactive with raising concerns and when people's needs change.

We observed that the care plan available at the homes of the people we visited and the care plan in the office were the same, so staff had access to the most up to date care plan. Care plans were reviewed on a regular basis. Care plans contained a section which stated, "To help us to get to know you better, we would like to know a little bit about you. You don't need to answer these questions if you don't want to." People were then asked questions about their marital and work background, whether they had children, likes and dislikes and hobbies. Daily notes completed by carers were detailed and in one example, we saw that the carer recorded that the person's leg was swollen. This was followed up by a visit from a District Nurse.

People told us they had no complaints and told us that they could contact the office if they had any concerns. Comments from people included, "Apart from asking the office to change one carer who I didn't particularly get on with that well, I haven't had anything to complain about. I know how to make a complaint because all the literature is in my folder and I think from how I've been treated in the past that they would listen to any concerns I had and hopefully do something about it" and "I have never had anything to complain about but if I did, I would pick up the phone and speak to the manager to see if we could sort it out without making it into a formal complaint as I usually find it's much better and hopefully you get a better outcome if you take this approach. Having got to know the manager over the last two years or so, I am fairly certain that we would soon sort anything out satisfactorily."

The service had a complaints policy in place and we saw that complaints were logged and investigated promptly with a response from the registered manager provided. Four formal complaints had been logged in 2016. On one complaint, which was in relation to MAR charts being incorrectly completed, the registered manager responded to the complainant apologised. They advised the person that the carer in question would be spoken with and invited to a supervision meeting to address the concerns and increased spot checks would take place. Complaints were not analysed for trends to identify if improvements could be made in particular areas. This was discussed with the registered manager who told us that a daily audit checklist had recently been implemented to monitor complaints as they came in.

The service requested feedback from people and records confirmed this. One person told us, "I think I remember filling in a survey once but it would've been a long time ago and I can't recall hearing anything about it again." This was fed back to the registered manager.

Staff spot checks which were recorded in people's care files also recorded that people were asked for feedback during the visits. On one occasion, feedback recorded stated, "They are excellent and if one is not available, another will take over."

A local placing authority recently contacted all people using the service to obtain feedback which was provided to the service prior to the inspection. The results showed that the response was positive overall, and where people had provided negative feedback, the registered manager told us that they would contacted and their concerns investigated.

Good

Is the service well-led?

Our findings

People and staff spoke positively about the registered manager. One person told us, "I think the manager and management of the service is very good. Everyone is very caring and you are never made to feel as if you are a bother if you contact them." Staff also spoke positively about the registered manager. A staff member told us, "[The registered manager] is really helpful. They listen. The manager will spend time and sit with me. I can express my views." Another member of staff told us, "[The registered manager] is doing her best. She is implementing new things to make carers more confident. She is trying and hopefully things will be better." We received positive feedback from health and social care professional about how the service was managed.

There was a clear management structure in place. During the inspection, the office appeared to be an organised and friendly environment. Phones were picked up promptly which reflected a comment received from a person using the service who told us, "It is so nice to get a friendly voice on the end of the phone when you ring the office, as in my experience it doesn't happen very often elsewhere."

The registered manager has been in post since December 2015 and was forthcoming around areas for improvement which have been addressed and areas which still required improvement. The registered manager provided numerous examples of improvements made to the management of quality assurance in the service in recent months, which included reviewing and implementing new MAR charts, implementing competency assessments for staff in relation to the safe management of medicines, infection prevention and control and safe moving and handling practice. They had begun changing from online learning to classroom based training, increasing the frequency of spot-checks, supervisions and appraisals. The registered manager had also recently implemented a daily data checklist for office based staff to complete. This included recording information such as details of visits cancelled, people who were reported to be in hospital, accidents and incidents, changes to regular carers with the reason and confirmation that the person was informed and any concerns reported to the office by carers and actions taken. The form also recorded compliments, complaints, telephone spot checks and actions taken and details of new care packages.

An action plan had been implemented by the operations director for SureCare which corresponded to the Health and Social Care Act 2008 Regulations 2014. We saw that the registered manager had actioned areas for improvement and the action plan was kept updated. Areas where actions had been taken included, implementing care plan and risk assessment training for senior care staff, accurate monitoring of supervisions and appraisals and implementing a tracker for spot checks. A field supervisor told us that they receive instructions from office staff monitor in relation to when a supervision or spot-check is due and evidence on people's care files indicated that spot-checks and supervisions were happening on schedule.

A monthly staff newsletter had recently been developed and was emailed to all staff. The newsletter contained reminders to carers in relation to medicines management, reporting concerns and attitude. The newsletter also contained the details of the carer of the month which was also a recent development to improve staff morale and reward good performance. Feedback from people and relatives formed part of the

criteria for the award.

Staff meetings took place regularly. Staff told us they found the meeting useful. One member of staff told us, "We always have regular meetings. They are sometimes repetitive but I learn something new." In addition office staff held a brief weekly meeting to discuss any concerns relating to people who used the service which escalated to the relevant healthcare professional.

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 11 HSCA RA Regulations 2014 Need for consent Regulation 11(1) Care and treatment was not always provided with the consent of the relevant person as the registered provider was not always acting in accordance with the Mental Capacity Act 2005. The registered provider did not ensure that staff were familiar with the principles and codes of conduct associated with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b) The service provider was not providing care in a safe way as they were not doing all that was reasonably practicable to mitigate risks to service users. Regulation 12(1)(2)(g) Medicines were not always managed safely and effectively.