Digital Home Visits Ltd

Vida London

Inspection report

8 Greencoat Place
London
SW1P 1PL

Tel: 02036530321
Website: www.vida.co.uk

Date of inspection visit:
12 December 2017
15 December 2017

Date of publication:
16 March 2018

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 12 and 15 December 2017 and was announced. We gave the provider 48 hours' notice of the inspection visit because the manager could be out of the office supporting staff or providing care. We needed to be sure that they would be in. This was our first inspection of the service since the provider registered with the Care Quality Commission (CQC) in November 2016.

Vida London is a domiciliary care agency that provides personal care to people living in their own houses and flats in the community across four London boroughs. It provides a service to adults and younger people. The provider operated their service digitally and information was stored and accessed electronically. At the time of the inspection 83 people were using the service.

.

The service had a registered manager who was on site during both days of the inspection. 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.

People had mixed views about the punctuality and the consistency of staff. Systems were in place to monitor this and the provider acted on people's concerns.

Background checks were carried on staff before they began work. Staff had received an induction and took part in a programme of training; however they had not received regular supervision. People spoke favourably about the caring nature of staff who took time to listen to them and said that staff upheld their dignity and privacy.

People were supported with their nutrition and given support with their medicines when this was needed. Where people required advice and treatment from health professionals they had access to healthcare services and their records reflected this.

Safeguarding procedures were followed when staff suspected people were at risk of abuse and staff knew how to report any concerns. People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Risk assessments contained guidance for staff to follow but records were not always updated to ensure staff had all the information they required to reduce the likelihood of harm.

New technology was being designed, piloted and updated to reflect people's needs and provide a more streamlined and effective service. Staff held mobile phones and could access and update people's records via the provider's app. The provider had been recognised for the design of the new app in several articles and television interviews.

Care records highlighted people's individual needs and lifestyle choices; however information was not available in an easy read format so they could better understand the services they received.

People had mixed views about the accessibility of the office staff. Their experiences of using the service had been sought through the use of surveys and spot checks in peoples' homes.

Quality assurance systems were in place but did not identify the issues we found. The provider worked in partnership with other organisations to benchmark their service and kept up to date with relevant good practice. Staff spoke positively about the overall management of the service and they were asked for their feedback about what the service could do better.

We made two recommendations about information being accessible to people and risk management. We found one breach of regulations relating to staff supervision.

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

Aspects of the service were not always safe.

Plans were in place to assess risks to people, however some required a review. Safeguarding protocols were followed if staff suspected people were at the risk of harm.

Recruitment procedures were adhered to and staff were vetted before they were employed.

People had mixed views on the provider's ability to provide them with consistent and punctual staff.

Staff supported people to safely manage their medicines.

Incidents and concerns were reported and lessons learnt to support the improvement of the service.

Is the service effective?

Requires Improvement

Aspects of the service were not always effective.

Staff had completed the required training so they could support people effectively with their care; however they had not received regular supervision to support them with their work performance.

Assessments of people's needs were carried out once they agreed to receive care but some assessments were not completed before care was delivered.

People had access to health practitioners and were supported with their nutritional needs.

People were supported with the choices and decisions they made about their care.

Is the service caring?

Good

The service was caring.

People and their relatives spoke about the caring and thoughtful

nature of staff.

Staff were matched with people so their individual needs were met and their independence was encouraged to ensure they led more fulfilling lives.

People made decisions about how they wished to be cared for and staff respected their dignity and privacy and understood the importance of this.

Is the service responsive?

Good

The service was responsive.

Care records were stored electronically and reflected people's choices and individual needs.

People knew how to make a complaint and concerns were acted on and resolved.

Is the service well-led?

Requires Improvement

Aspects of the service were not always well-led.

Checks were carried out to audit how the service was operating, but these did not evidence the issues we found.

Some people told us they experienced difficulties getting through to the office staff. They had been asked for their views and feedback so the provider could find better ways to deliver care and support.

Staff spoke favourably about the service and where asked for their feedback to improve the service provision.

The provider worked in partnership with external stakeholders and kept up to date with relevant practice in adult social care.

Vida London

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.

Why we inspected – This was a routine first inspection of the service since the provider registered in November 2016.

We inspected Vida London on 12 and 15 December 2017. We gave 48 hours' notice of the inspection because staff could be out of the office supporting staff or visiting people in their homes and we needed to be sure that someone would be in. The inspection was announced on the first day and we told the provider we would be returning to continue with the inspection for a second day.

The inspection was carried out by two inspectors on the first day and one inspector on the second day. An expert by experience made telephone calls and spoke with six people and six relatives to seek their views about their experience of using the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we made telephone calls and spoke with 18 staff to obtain their views about the service. We checked information that the Care Quality Commission (CQC) held about the service including any notifications sent to CQC by the provider. The notifications provide us with information about changes to the service and any significant concerns reported by the provider. We used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.

.

We visited the office location and spoke with the chief care officer, operations manager, assessment and client needs manager, the recruitment manager and the registered manager. During the visit the provider gave us a presentation of what the services had to offer and a demonstration of their technology. We reviewed five people's care files and their medicines records. We checked eight staff training and

recruitment records, quality audits, minutes of meetings and a sample of their key policies and procedures. In addition to this we looked at two 'share your experience' forms that had been sent in to us from people telling us about poor or good care being provided.

After the inspection we made telephone calls to representatives of four local authorities for their feedback about the service and spoke with two of them in the London boroughs of Greenwich and Kingston.

Requires Improvement

Is the service safe?

Our findings

People's risks assessments were not always updated to ensure the provider could be responsive to their changing needs. Where risks to people's safety, health and welfare were identified risk reduction measures were in place to mitigate the risks. People's care records included guidelines for staff to follow so people received appropriate care and took into account their home environment and any equipment or adaptations they used. For example, one person's risk assessment identified they needed help to reduce the risk of pressure sores and maintain their skin integrity. However two people's records had not been updated when their needs had changed. For one person, records showed that a review of their needs was carried out two weeks before our visit which found their mobility needs had decreased which meant they no longer required two to one care, but their records had not been updated to reflect this. Where another person had behaviour that challenged the service the lone working risk assessment had not been fully completed to demonstrate how staff should manage this risk. This meant that staff did not always have the full information to mitigate risks to make certain that people were safely supported in their homes. We recommend that the provider review risk management systems to ensure that records provide staff with sufficient up to date information to adequately protect people from avoidable harm.

Staff were provided with aprons and gloves, where required, to maintain infection control and people's records showed how staff were required to dispose of clinical waste.

People told us they felt safe with the care provided. Their comments included, "I feel extremely comfortable and very safe with my carer. [He/she] looks out for me and knows when I am down and knows how to cheer me up and take care of me" and "I am very happy with my care and I feel safe in the knowledge that they will be here to help when it is required." And a relative explained, "[My family member] feels safe in their hands and does look visibly relaxed when they arrive, almost relieved that help has come."

The provider had a safeguarding policy and procedure in place. The staff we spoke with were able to describe the different types of abuse and were knowledgeable about the provider's procedures for whistleblowing. Staff explained they had completed safeguarding training during their induction and were also given information about the whistleblowing procedures at that time. Staff files included records for staff induction training and/or care standards training, which included the importance of safeguarding and whistleblowing to keep people safe from harm. We had received one safeguarding notification which was reported by a member of staff to the provider alleging they had witnessed neglect. The registered manager had followed the provider's safeguarding protocol by alerting the local authority and informing the Care Quality Commission (CQC) as required by law.

Safe and effective staff recruitment systems were in place and followed by the provider which helped to ensure that people were supported by staff who were suitable. Staff files contained two references and photographic identification, evidence of their right to work in the UK and their curricula vitae (CV). Staff had a satisfactory Disclosure and Baring Service (DBS) check. The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions.

We received mixed views from people and their relatives about staff arriving on time to their care visits. One person said, "The carer does arrive on time and is very helpful when [they're] here" and a second person commented, "[The staff member] does arrive on time and is really as punctual as traffic allows." A third person explained, "[Staff] can sometimes be late but will always make up the time and will always let me know if [they] are running late." People's relatives commented, "They never come when they say they will, so no they certainly do not arrive on time" and "They gave the carer five minutes between calls when it was at least a half hour journey so her timings were completely out all day and I had to wait and wait for someone to come and wash and change [my family member]."

We checked 11 staff rotas over a period of one month and found that staff had been allocated enough time between visits. The staff we spoke with told us that they had enough time to care for people and that they were given enough travel time between calls with the exception of one staff member. They said that they had repeatedly spoken to the provider about not having enough travel time and there had been no action to address this which meant they were late for one of their calls. We asked the registered manager to address this. The provider used a system called 'people planner' that matched people's locations with staff who lived close to their local area.

Records showed there were systems in place to monitor late calls and evidence was seen of the action that was taken to address people's concerns. A representative of a local authority explained the provider openly sent them weekly reports of late visits or any concerns that had been raised. This was not a requirement but something the registered manager chose to do in line with their duty of candour.

People and their relatives had mixed experiences in relation to continuity of care as they did not always have the same staff supporting them. One person said, "We do get the same carer thank goodness as in the first few months we had a disastrous time with a lot carers which was not good at all, but then we really hit the jackpot" and another person explained, "I nearly always have the same carer and I just don't know what I would do without them." A relative said, "There is never enough cover but a supervisor came here to care once and it was almost organised for that two weeks and then they left."

The registered manager explained that they found it difficult to recruit staff in certain localities, but were looking at ways to manage this, and would give people enough notice if they were unable to cover their care call . They further added that people were allocated particular staff but at times people were supported by different staff due to planned or unplanned leave. The provider spoke about managing people's expectations, and would speak with people and their relatives if they were allocated a different member of staff but knew the importance of providing the same staff to meet people's needs for continuity. For example, records evidenced that a person living with dementia was not responsive to some staff, but the provider had allocated one staff member to work with the person who had built a positive working relationship with them. Feedback had been sought from the person during a review of their needs who described the staff member as "fabulous".

People told us they were supported appropriately with their medicines. One person commented, "I organise my own medicines but [staff] would always be happy to collect a prescription for me if needed" and another person said, "I self-medicate but [the staff member] is very reliable and will always check that I have taken my medicine just in case I have a lapse of memory."

Staff supported people with their medicines as prescribed and completed the required medicines training. Records held information about the type of medicines people took, any side effects they may experience, contact details of health practitioners and if their relatives were involved with the management of their medicines. The registered manager explained that some people they supported were able to manage their

medicines independently. The records we checked showed that staff had signed to evidence that people had been given or prompted to take their medicines, when required. Medicine records in people's homes had been audited during spot checks.

A business continuity plan was in place which included business impact assessments for adverse events, such as bad weather or if staff were not able to attend a visit. Concerns or major incidents were escalated to the registered manager. An out of hour's service was available for people to contact the provider at any time. A WhatsApp group has been solely set up for the Vida office coordinators and field supervisors, to be able to keep in touch with each other and the registered care manager, over the weekend. Calls made to the out of hour's number were logged on a central communications portal so the provider could analyse the concerns raised and monitor how people's concerns had been addressed.

We looked at the policy and procedure for managing incidents and the staff we spoke with knew how to report incidents and concerns. Incidents were being reported using an online form or application. All reports were collated and included next steps with due dates and lessons learnt. We saw that some learning from the incidents had been shared with staff in the provider's newsletter. Reoccurring themes had not been identified; but the management team reviewed all incidents and were in the process of setting up an online system to identify any patterns or trends.

Requires Improvement

Is the service effective?

Our findings

Staff did not receive regular supervision necessary to enable them to carry out their duties effectively. The provider explained that staff supervision should be held four times per year. Although three staff we spoke with said that they had been supervised we found no records of these meetings and despite four members of staff being employed for more than 10 months there were no records of staff supervisions in all of the staff files we checked. The registered manager acknowledged the gaps in staff supervision and agreed to make this a priority. This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Four of the staff files we looked at included records of a probation review conducted within three months of their employment. The provider held its first open forum for staff to attend in September 2017, but the uptake was low and the provider had a system in place to share discussions with those who had not attended. The provider planned to hold the forum for staff to attend every three months.

Three of the staff we spoke with said that they had received a spot check to review the standard of care that they were delivering. One staff file looked at contained records of a spot check carried out in November 2017 and the provider had made observations to assess if they were carrying out the tasks correctly and check their overall performance. We saw recommendations had been made about the delivery of the care package at the time of the spot check and we saw evidence that the recommendations had been implemented. Staff had not received an appraisal because they had not been employed for more than a year at the time of our visit.

Records held information about the training staff had completed and the staff we spoke with confirmed that they had received training when they had started employment. This comprised of a face to face two day induction programme. The subjects covered included training in personal hygiene, pressure sore management, safeguarding, the Mental Capacity Act 2005, dementia, infection control, manual handing and medicines awareness. Staff had also completed the online Care Certificate programme, which covered the same topics.

We viewed people's initial assessments that had been sent to the provider by the placing authority so these could be included in people's care plans. Where people purchased care with their own budgets, the provider told us they visited their homes within 24 to 48 hours to check the tasks they needed help with. However some assessments were not completed before staff were allocated to work with people. For one person we found their assessment had not been completed until one month after the care was provided. For a second person we found an assessment had not been carried out until three months after staff were allocated to work with the person. In both of these cases the two people had support plans in place. We pointed this out to the registered manager, who agreed a more responsive and thorough approach was required when completing these assessments and said they would take action to ensure this was carried out.

People were encouraged to have sufficient food and drink and staff helped them to purchase groceries at the local shops. One person explained, "[The staff member] will always make sure I have had something to

eat and drink when [they] arrive, and if not, will make me some toast and marmalade and will make me a sandwich for lunch before [they] leave and a nice cup of tea" and another person said, "The carer will always volunteer to nip to the shops for bread or milk and is very willing to help in any way [they] can."

Plans identified that some people's relatives prepared their meals and others needed support with the purchase, preparation and storage of food items. People's food preferences and dietary needs were recorded so that staff knew the preferred dishes people chose to eat. Assessments of people's nutritional needs were recorded to show the type of support they needed with their meals and how they would like them to be prepared, such as soft and blended food to help them with eating or drinking.

Where one person had difficulty with eating and drinking a risk assessment evidenced how to manage the person's meal time to support them effectively. Another person told us that staff took the time to encourage them to eat and suggested different types of foods they would like to try and explained they found this beneficial as it helped increase their appetite. They commented, "I hadn't been able to eat and just wasn't interested but [the staff member] was very good at coming up with alternative foods that I might like and that I might find easier to keep down. That was brilliant and cheered me up greatly."

People had access to healthcare services and were supported by health practitioners to help manage their health conditions. One person commented, "If I need anything from the pharmacy or doctor the carer will always help" and a second person told us, "I have no difficulties seeing doctors, dentists or the like and my carer will come with me if needed but I am ok on my own."

People's care records included the details of involvement with health and social care professionals. People's plans outlined the details of people's medical conditions so that staff could understand their needs and provide the correct and safe care to people. A relative told us, "The carers are great and help us a lot with trying to sort out help for [my family member]. For example, they explained how to get [my family member] assessed for continence in order to get the free supply of sanitary equipment needed."

People were consulted during reviews of their health needs and records held information of health professionals input to provide training for staff on how to effectively manage people's health conditions. For example, a member of staff was caring for a person who required support with percutaneous endoscopic gastrostomy (PEG) feeding and records evidenced they had received specialist training from a district nurse on how to manage this effectively. For another person who was at risk of falls we found the provider had arranged for a sensor mat to be put in place and explained to staff the reasons for this.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA). The 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. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

People told us that staff sought their consent before helping them with the tasks they needed to be supported with. One person said, "I make all my own decisions, I am not potty just frail. When [the staff member] arrives we have a routine and we have a chat and just get on well so nothing is ever done without my permission or without us knowing what we are doing together" and another person explained, "I make all my own decisions and my carer will help me decide sometimes when I am dithering."

Care plans recorded the key aspects of people's care and demonstrated where they could make day to day decisions about their care. People's communication needs had been assessed and showed how consent was given if they were unable to verbally communicate, for example, with the use of their body language. A relative commented, "It is hard to communicate fully with [my family member] sometimes but they always make the effort I will give them that." For one person their records showed where staff were required not to dispose of a person's unwanted groceries without their permission. For another person an assessment had been undertaken and written notes showed their relative had been appointed to make decisions on their behalf for their health, welfare and finances. Where a person's capacity had reduced the provider acknowledged they would report this to the local authority so best interests meeting could be held and decisions made about their care.

Good

Is the service caring?

Our findings

People spoke very positively about the staff that supported them and described their nature as being caring and considerate of their needs. Their comments included, "I would describe [the staff member] as indispensable a godsend and really a friend I would say, they know me inside out", "The carer as a sensible, caring person", "I would describe the carer as confident and intelligent [they] have got to know us very well and is extremely patient and jovial too" and "The carer is conscientious, very helpful, has a good attitude and most of all is warm friendly and most reliable. Can't beat that, can you? [The staff member] knows my idiosyncrasies warts and all, and is most helpful."

On the second day of our visit we were shown a video of a service case study that had been aired on television. This demonstrated examples of how people benefitted from building caring relationships with individual staff which in turn had maximised people's independence. The provider spoke about the staff member's previous occupations and what inspired them to become care workers. A social care professional told us when the provider had seen opportunities to improve someone's life they had worked well with people to be less reliant on staff support.

Each staff file held a 'carers profile' which gave an overview of staff's interests and skills, including their training, education and languages spoken. The provider also used technology that helped ensure that people were matched with the most appropriate care worker. This enabled the provider to match staff to people with specific care and/or cultural needs. Staff told us how they helped people maintain as much independence as practically possible and a staff member commented, "If a client is able to dress themselves partially, we let them do it and help them with the rest."

People were encouraged to be involved in making choices about how they wished to receive their care and staff were willing to adapt the way they did things to suit people's needs. One person told us, "[The staff member] will always ask our views on things and make sure things are done to suit us not [their] timing schedule" and a relative said, "The carers will always chat with [my family member] and try to see what [they] are happy with and if there is anything else they can do to make [them] comfortable and happy."

Notes held written details about how people were supported to make choices about the things that were most important to them. For one person they had a requirement how they would like the staff to also care for their cat and feed the pet one pouch of food when they visited and this task was carried out. Where people's spouse, relatives or friends helped with additional task in their homes, such as the management of medicines, nutrition or domestic duties this was included in an assessment of people's needs.

People told us their privacy and dignity was upheld and that staff understood the importance of this. Their comments included, "I like my privacy. I suppose I would say I am shy so [staff] will always stand just outside the door when required and will not come back until I call [them] in to do so" and "Without fail the carer will knock on the door before coming in to my bedroom." And a relative explained, "They are jolly good at protecting [my family members] dignity if I enter they always make sure [my family member] is covered."

Staff explained when they supported people with personal care this was done in a dignified way by closing the doors and curtains and asking people's permission before entering their rooms. One person's records showed a detailed plan of how they preferred to be supported with their personal care, including what products should be used on their skin and where to locate toiletries in their home.

The provider had received compliments from people who used the service who had written, 'Very happy with the care this morning', 'Thank you for the care and support use me as a reference' and 'The carer is cheerful and helpful'.

We noted that information such as care records and the provider's policies were not available in an easy read format if people requested this to help people understand the care services available to them. We recommend the provider updates their information in accordance with the Accessible Information Standards to ensure people are provided with information they can easily read.
.

Good

Is the service responsive?

Our findings

People told us they were confident in staff's ability to provide care that was responsive to their needs. One person said, "This carer that I have had has enhanced my education enormously and given me the confidence in my ability to recover, so this had been a positive experience" and another person commented, "We have each other so we do not need a carer to help with our interests but I have no doubt that [the staff member] would."

New technology was tested and used by the provider to drive efficiency and improve standardised care. We were given a demonstration of the digital technology the provider used. The system was designed so that staff could be matched to people's specific needs. The matching process was built into the technology so that the provider could plan visits more effectively and people would be supported by staff that met their care requirements. Staff had mobile phones installed with the provider's app. This allowed them to access people's care records, check what shifts were available, accept or refuse work, access people's initial assessment from the placing authority and the provider's assessment. People's care records were all stored electronically and updated by office staff so staff had easy access to this information during their care call. Daily notes were updated via the app by staff once they had completed their care call. These records were then uploaded by staff which allowed the management team to have immediate access to check if the correct care was delivered.

An online platform, known as 'Hubspot', was used to document communication with staff and people. The system could be accessed out of hours. The system tracked all communication and was integrated to synchronise communication between people and staff when they were related. There was an additional system for reporting risks online. The management team reviewed all risks, identified trends and themes and had a system in place to share the learning with staff as necessary.

The management team explained that the technology was being piloted by a number of staff and they were working on streamlining the digital system for this to be more effective. This would include adapting the technology to include easy read information to comply with the Accessible Information Standard, as one person had requested this. The provider followed their Information security and governance policy. This included the use of secure authentication codes only allocated to the staff that accepted the care visit so they could access people's records. Once the care visit was completed staff could no longer view the person's records online. Data was backed up on the provider's server to ensure if any information was lost this could be retrieved.

People had a care plan that set out how their care and support needs would be met and the type of support they wanted to receive. They were fully involved in the preparation of their plans and received a copy of this. One person said, "I do have a care plan that says what care I need but I always have the same carer and if [the staff member] is away, which is hardly ever my brother and I cope" and another person explained "I have a care plan but my carer knows me well." And a relative said, "The carers let us know if [my family member] is okay and what extra needs they have too, I rely on them."

Care plans demonstrated the type of support people wanted to receive. Some people were provided with 24 hour care such as live in carers to provide companionship, support with domestic tasks and practical help and accessing the community for appointments. Other people required support with their personal appearance, help with their medical conditions and assistance with nutrition and medication daily and/or on different days once a week.

People were supported by staff who understood their life histories and leisure interests. One person's records detailed how they had previously worked in a health facility, attended a day centre and helped with fundraising that benefitted other people. Another person's records showed how they liked poetry and the significant relationships with their children. People we spoke with told us that staff took the time to listen and talk with them about their interests. One person said, "I like reading my newspaper really and watching current affairs so we do chat about what is going on in the world."

Where people's behaviour challenged the service records demonstrated the provider worked in proactive ways to manage this. The registered manager showed us the records for a person with complex needs and how they worked with the person and staff to gain a better understanding of how best to support the person in their home. A representative of a local authority told us that they had referred complex care packages to the provider. They said the provider had managed these care packages well and that people were receiving good care from the staff who supported them.

Care guides about the service were available for people and this was also displayed on the provider's website. This included information on the support people could expect with particular health conditions with examples of case studies linked to these. For example, details on caring for people with cancer, dementia and multiple sclerosis and information about domiciliary care to help people understand what to expect. There were also guides explaining benefits people may be entitled to such as attendance allowance.

Complaints were acted on and responded to when people were unsatisfied with the service. People told us they knew how to raise a complaint and information was given to people when they began using the service to inform them about how to do this. A complaints log was kept by the provider and showed that the written and verbal complaints people raised had been responded to within a satisfactory timescale and resolved.

At the time of the inspection the provider was not supporting people who needed support with palliative care because the provider had not yet received referrals for people at their end of life.

Requires Improvement

Is the service well-led?

Our findings

Systems were in place to monitor the standard of care. The registered manager analysed information about the quality and safety of the service. We saw a record keeping of daily audits were carried out. This involved reviewing 30 randomly selected care records to check that staff were checking in upon arrival and out when leaving a person's home, safeguarding concerns, late arrivals for visits whether people's condition was deteriorating and the quality of people's care notes. However these did not pick up the issues we found with lack of staff supervisions and more effective auditing was required in relation to people's risk plans and initial assessments. The registered manager was proactive in addressing and responding to any issues brought up during the inspection and told us they were committed to making improvements at the service.

Some people and their relatives told us they no issues speaking with staff based at the office but others explained had experienced difficulties contacting the office. Their comments included, "I can contact the office at any time I just don't wish to as things run smoothly without the need. As far as I am concerned things could not go better at the moment thank you" and "There appears to be a barrier between the service user and the agency office. Poor delivery or communication." A relative told us that they had asked for staff cover three weeks ago for but I had not heard back from the office staff. Another relative told us they did not know who to speak with in the office, and they did not return their calls. We fed this back to the registered manager agreed to check what these issues were.

Surveys had been sent to people to check the quality of the service and improve the provision of care. People were presented with questions that asked about staff punctuality, if people were treated with dignity and respect and if their care plan was being followed and the results were overall positive.

The provider had also sent out staff surveys which showed positive responses and they had recognised that not all staff had returned the surveys. The management team spoke about learning from the low response rate and spoke about new ways to engage staff to ensure more of them submitted their feedback. The management team told us there was a keen interest in staff in knowing there would no fear of reprisals and would be learning from this.

The majority of the staff we spoke with said that they were happy working for the provider and that they were supported and listened to. Staff were provided with a carers handbook, which included policies and procedures on professional development, incident reporting, personal presentation and conduct, confidentiality, dealing with emergencies and the use of hoists. The provider produced a newsletter which was shared with carers. The provider told us that this was to be sent out on a monthly basis. The newsletter provided updates to carers on a variety of topics, including medication safety and respecting people's privacy and dignity.

The registered manager kept up to date with relevant and good practice by working in partnership with other services and benchmarking to set standards new standards of care. They had attended the Care Quality Commission (CQC) co-production group and spoke about testing that was done for the Provider Information Return. Staff meetings were held weekly for office staff to discuss how the service was operating

and relay any suggestions and concerns. The management team had spoken at a number of events including a social care conference and during adult social care functions.

.

Events were hosted and attended by the provider to enhance people's well being with activities that were reported to be beneficial for people and those living with dementia. These functions were advertised on the provider's blog and included, art meditation, music and sing-alongs and a bake sale for Silver Sunday to raise money for a healthcare charity.

The digitalised system that the provider had developed had been recognised as one of the top 50 apps and had led to the provider being mentioned in several well-known technology magazines. In addition to this the provider had been interviewed for magazines and appeared on national television to discuss the technology being used in healthcare and the social impact of this. The chief care officer explained, "We like to lead by example and revolutionise the care industry, we are a learning organisation."

The provider kept up to date with relevant areas of good practice through membership of a number of professional organisations, such as dementia friends and the United Kingdom Homecare Association (UKHA) who offer advice and accessible resources for providers who manage domiciliary care services. The provider is required by law to notify CQC of incidents that occur in the service and we had been informed of these as required.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing How the regulation was not being met: The provider did not ensure the staff receive appropriate supervision to enable them to carry out the duties they are employed to perform Regulation 18 (1)(2)(a)