Compassionate Care Ltd

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Inspection report

Castle Hill Court
Mill Lane
Ashley
Cheshire
WA15 7JU

Tel: 01618709074
Website:www.compassionatecareltd.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We inspected Compassionate Care Ltd on 15 and 16 February 2016. Due to the nature of the service we contacted the registered manager one working day before the inspection so that we could be sure there would be someone at the office when we arrived on the first day. The company registered with the Care Quality Commission (CQC) in February 2015 and this was their first inspection.

Compassionate Care Ltd is a domiciliary care agency providing personal care and companionship to about
50 people in Trafford and Cheshire East. Care workers support the people using the service with a wide range of needs, including assistance with washing and dressing, accessing activities, attending health appointments, cleaning and making meals.

The service had a registered manager who was also the company's managing director. 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.

At this inspection we found that not all care workers had not received training on the Mental Capacity Act (MCA). It was not clear from care records which people had relatives with lasting power of attorney to make decisions on their behalf. Some relatives had signed consent forms for people who had not had an assessment to determine whether or not they could make their own decisions.

Care plans were person-centred but did not always address all of people's identified care and support needs.

We found breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulation 2014. You can see what action we have told the provider to take at the back of the full version of the report.

People told us that they felt safe when using the service; their relatives also said they felt people were safe. Staff we spoke with understood about safeguarding vulnerable people, they had received safeguarding training and said they would report any concerns appropriately.

The service had enough staff to attend the care visits scheduled. People and their relatives said that care workers arrived on time and stayed for the duration of their allotted visits.

Some people using the service were assisted with their medicines; we saw that these were well managed by the service. Care staff administering medicines received training.

The service undertook risk assessments for all aspects of the care and support people received in their homes. Care workers had been trained in infection control and used personal protective equipment when they supported people with personal care.

Staff received the training they needed to care for the people safely. New care workers who had not previously worked in health and social were undertaking the Care Certificate. The care certificate is a nationally recognised set of induction standards for people new to working in care.

Care workers had received regular informal supervision and had a documented annual appraisal. They also attended regular team meetings at which the vision and values of the service were discussed.

The people who needed help to buy food or prepare meals were happy with the support they received from care workers. The service also rearranged visit times in order to accompany people to healthcare appointments.

People and their relatives told us that care workers respected their privacy and dignity and promoted their independence. Care workers we spoke with could provide examples of how they did this.

Care workers could demonstrate that they knew people's likes and dislikes and the service tried to match people with care workers that they would get on with.

People and their relatives (when appropriate) were involved in developing their care plans. They told us that the service was flexible and that they could change their care plans if they wanted to. Daily records reflected people's care plans and people told us that the content was accurate.

We saw that the service acted upon feedback and had dealt with complaints in a timely way in accordance with their complaints policy. None of the people or relatives we spoke with had ever made a formal complaint.

The service had an audit and monitoring system in place for care plans, medicines and accidents and incidents. People and staff received annual surveys asking for feedback on various aspects of the service so that improvements could be made. We saw that the registered manager had acted upon feedback received in the November 2015 survey.

Care workers were actively encouraged by the registered manager to get involved with service improvement; they also understood the vision and values of the service. The registered manager gave recognition to staff members and they felt valued as employees.

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.

People using the service told us they felt safe when they were supported by care workers. Care workers had received safeguarding training, they knew the different types of abuse and said they would report any concerns.

There were sufficient staff to cover visits and people told us that care workers arrived on time and stayed for the full duration of their visits.

Medicines were administered safely and the service risk assessed their home care provision so that people could be supported safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Care workers had not all received training on the Mental Capacity Act and documentation showed that the service was not working in accordance with the legislation.

Staff received the training they needed to support people safely and received regular supervision and annual appraisal.

The people supported with food shopping and meal preparation gave us positive feedback about the assistance they received. Care workers accompanied people to healthcare appointments.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were caring. They also said that care workers promoted their privacy and dignity and staff could give examples of how they did this.

Staff knew people well as individuals and could describe their likes, dislikes and preferences. The service tried to match people to care workers that they would like.

Staff described how they tried to promote people's independence by encouraging them to do as much as they could for themselves and getting them involved with household tasks.

Is the service responsive?

Requires Improvement

The service not always responsive.

Care plans were person-centred but some we saw lacked detail relating to aspects such as mobility, dementia and skin integrity.

People and their relatives were involved in designing their care plans and told us that the service was flexible and adapted to their needs.

The registered manager used feedback to improve the service and dealt with complaints in line with the service's complaints policy.

Is the service well-led?

Good

The service was well-led.

A system of audit and monitoring was in place and was in the process of being revised and improved.

People and staff were asked for feedback about the service in annual questionnaires. We saw that the registered manager had acted upon feedback from the most recent survey.

Care workers felt valued by the registered manager. The service also worked in partnership with other businesses and organisations.

Compassionate Care Ltd

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.

Our inspection took place on 15 and 16 February 2016. We telephoned the registered manager one working day before the inspection so that we could be sure there would be someone at the office when we arrived.

The inspection team consisted of one adult social care inspector.

Before the inspection we reviewed the information we held about the service. This included the local authority safeguarding team and clinical commissioning group, Healthwatch Trafford and three healthcare professionals who were involved with people using the service. None of the people using the service were funded by the local authority so they had no information to give us. Healthwatch Trafford had no concerns and the healthcare professionals working with people using the service we contacted each gave us positive feedback.

During our inspection we spoke with the registered manager, a company director, the assistant manager, a team leader, a training coordinator, four support workers and an administrative assistant.

We spent the first day of the inspection at the company's registered address speaking with staff and looking at records; these included five people's care records, three staff recruitment files, various policies and procures and other documents relating to the management of the service. On the second day of inspection we visited four people who used the service in their own homes; this included looking at the care documents kept there, with the person's permission. After the inspection we telephoned four more people at home and seven of their relatives.

Good

Is the service safe?

Our findings

We asked people if they felt safe when they used the service and all of them said they did. One person told us, "I feel safe and confident when I'm with them", a second person said, "Yes, I feel safe", a third person asked if they felt safe replied, "Oh yeah", and a fourth said, "Definitely." We asked people's relatives if they thought their family members who used the service were safe. They told us, "Yes, I do, yes", "I can go out knowing [my relative] is in safe hands", "Yes", and "100% yes."

All the care workers we spoke with could describe the forms of abuse people using the service might be vulnerable to. They told us they had received training in safeguarding adults and we confirmed this by looking at the company's training matrix; care workers also said they would report any suspicions of abuse to their managers. One care worker said, "I'd go to my boss. You've got to say something", a second said, "We build trust with clients so they'll confide any problems", and a third said, "You look for things that are out of the norm." This meant that care workers knew how to identify the signs of abuse and would report any suspicions appropriately.

People using the service were supported by care workers visiting their homes at an arranged time for an agreed duration. We asked people if care workers arrived on time and stayed for the duration of the time they were allocated. One person told us, "Yes, they've been very good." All of the other people we spoke with agreed and no one reported having a missed visit. A relative commented, "Yes, they're on time and they have to book in and out using [my relative's] telephone." People reported some changes in staff. One person said that this was mainly due to their regular carers being promoted to other positions within the service; another person said they were happy to see different staff as it gave them an opportunity to meet new people. A relative said that they liked to know which care workers were coming for each visit; they told us, "We need to know in advance who's coming and they tell us." This meant that care workers were reliable and did not cut care visits short.

We asked the registered manager how visit rotas were managed. She told us that a computerised system was used to book people's visits and to allocate care workers to them. An administrative assistant showed us the system, explaining that it ensured people were not missed off the rota, even when their regular care workers were off sick or on holiday. In addition, care workers dialled into the system when they arrived at a person's house and again when they left. The administrative worker also said that if the care workers did not dial in within 15 minutes of their scheduled visit, the system alerted the team leaders who would investigate and arrange to cover the visit. We asked the registered manager how she monitored care workers' visit times. She showed us data printed from the visit scheduling system, which had the times a care worker had dialled in and out, the visit duration and the expected visit duration. We checked the records for five care workers' visits for one week of calls in January 2016 and found that all visits had been for the full duration and had started and ended within 20 minutes of expected times. The registered manager described using the system to identify and discipline a care worker who had been cutting visits short. This meant that the service had an effective system in place to rota care

workers which prevented missed visits; it was also used by the registered manager to audit visit time and ensure the reliability of the service.

The care workers we spoke with told us that there was sufficient time allocated between visits for them to travel to the next person's house. Two care workers commented that since the company had grown, travelling between visits had become easier as distances between visits had decreased; another care worker told us, "My visits are fine."

We checked to see if recruitment procedures were in place to ensure only staff suitable to work in the caring profession were employed. We looked at the recruitment records for three care workers and found that all had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups. The personnel files we looked contained a copy of the original application in which gaps in employment were explained. Each file also contained two written references and records of their interview. Employees had provided photographic identification which had been copied and stored on file. This meant that new care workers employed were suitable to work with vulnerable people.

The service had a contingency plan for various emergency situations, for example, fire and loss of electricity supply at the office. People's care files contained risk assessments for various aspects of the care and support they received at home. These included mental health issues, skin integrity and nutrition, as well as various aspects of their homes, such as electrical and gas equipment, pets and the location of smoke alarms. Each risk identified had details included on how the risk should be mitigated. We saw in home care files that care workers checked the emergency pendants of those people that used them weekly, to make sure they were working and could be used to summon help if it was needed. In the care file of one person who used oxygen we found detailed instructions about the risks associated with its use and what care workers should do in the event of any problems. This meant that the service was aware of the risks of providing care to people in their homes and planned to mitigate the risks that were identified.

Some of the people using the service were supported with their medicines. All of the care workers we spoke with said that they had received training in medicines administration and we confirmed this by looking at the company's training matrix. We looked at the medicines administration charts for two people supported to take their medication by care workers. Medicines were written up clearly and recorded as being given consistently, except for on one medicine record where a signature had been missed for medicines on one day. We checked the daily records for the same day and could see that the care worker recorded that the person had been assisted to take their medicines, so the omission was the signing of the medicine record, not administration of the medicines. We raised the issue with the registered manager who said she would investigate to determine whether the care worker required further training.

One person we spoke with received assistance with their medicines; they told us, "They remind me about my medicines." A relative we spoke with commented, "I'm really happy and reassured – they help [my relative] with [their] medication." This meant that the service was effective at supporting people to take their medicines.

Some of the people using the service received assistance from care workers with their personal care, for example, with having a wash and using the toilet. We asked people and their relatives if care workers always washed their hands and used personal protective equipment (PPE), such as gloves and aprons when assisting with personal care. One person said, "They do (use PPE)", another person said, "Yes, they have that alcohol gel stuff to use", and a relative told us, "Yes, they do wear aprons and we keep a stock of gloves and things in." All of the staff we spoke with said that they used PPE when it was required; one care worker said, "I wash my hands as soon as I arrive at a client's house." We saw from the training matrix that all care workers had received training in infection control. This meant that staff were aware of infection control measures and used PPE when it was required to keep people safe from infection.

Requires Improvement

Is the service effective?

Our findings

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to make 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 who live with conditions such as dementia or those with learning disabilities sometimes lack the capacity to make some decisions, for example, how to spend their money or where they live, but retain the capacity to make other decisions, for example, what hobbies they enjoy or what food they'd like to eat. Sometimes people can make decisions with support or be better able to make a decision at a certain time of the day. It is important that people who may lack capacity are assessed to find out which decisions they can make, which they need help to make and which decisions need to be made for them. Decisions made on people's behalf under the MCA are called best interest decisions.

The MCA assumes that all people have capacity to make their own decisions; capacity assessments are only required when it is thought people may lack capacity to make their own decisions. Other people, including relatives, cannot legally make decisions on a person's behalf, unless they have been granted lasting power of attorney. We found that Compassionate Care Ltd was not providing care in accordance with the MCA. Care plans for people living with dementia did not include capacity assessments for their ability to consent to receiving care, to help manage their money or for the service to support them with medicines. One person had a mental health care plan compiled by their mental health team; it stated that the person did not have capacity to manage their own finances. We also noted that a consent form for photographs to be taken and for their information to be shared with other healthcare professionals was signed by a relative, although there was nothing else on the person's files relating to their mental capacity or how they made decisions. We saw in another person's file that a relative had signed their consent form; it was only when we queried this that we were told that the person's relative had lasting power of attorney. This was not documented in their file. In a third person's file, on a document which recorded a review of their care plan it read, 'Spoke to [person's] family and they are happy with the support' and 'All support in place (family happy).' It was not clear whether the person had been asked if they were content with the support they were receiving. In another person's file it was noted, 'If the weather is bad, we have permission from the family to take [name] out in the car', although there was nothing to suggest that the person could not make this decision for themselves. Under the MCA, a person's family can have an opinion or make suggestions as to what a person lacking capacity may wish to happen, but they cannot grant permission for this.

We asked staff if they had received training on the mental capacity act; those we spoke with all said they had not and did not know what it entailed. For example, we asked care workers what they would do if a person said they felt poorly and asked them to call their GP for them. One care worker said they would ring the person's relative and ask them first; a second care worker told us that they would ring the GP for the person as it was them that they were caring for. This demonstrated that staff did not all assume that people had capacity to make their own decisions. We were informed by the registered manager that nine of the 15 support workers had received training on the MCA.

The lack of adherence to the principles of the MCA and the lack of staff understanding of the MCA constituted a breach of Regulation 11 (1) (3) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked the people and their relatives if they thought the care workers who supported them were well trained. People told us, "Well trained? Yes", "Oh yeah, they know what they're doing", "Yes, absolutely", "Yes they are", and, "As far as I know, yes." We also asked relatives if they thought the care workers were well trained, one relative told us, "They appear to be, yes", a second relative said, "Yes, I think so", and a third replied, "Absolutely, yes."

Staff told us they had received training to help them fulfil their roles; one care worker said, "My training is up to date." The training matrix showed that care workers had attended mandatory training courses on safeguarding, fire safety, infection control, health and safety and food hygiene. Additional training courses had been identified as required by care workers, such as continence and record-keeping. We saw that a 2015/2016 training plan was in place with dates allocated. One care worker said that they had attended courses in dementia care and mental health since joining the company. Another told us they could ask for more training if they wanted it, they added, "They're always asking us what training we want." This meant that, with the exception of MCA training, care workers received regular training to help them meet the needs of the people they supported.

The service had the equivalent of one and a half training coordinators who arranged and provided training to the staff at the service. We spoke with one training coordinator who explained the training matrix to us. They told us that courses could be tailored for staff supporting people with certain conditions or needs, and said that training was being organised for care workers around supporting people with epilepsy and learning disabilities. A healthcare professional who was involved with a person using the service confirmed that they were in the process of arranging a date to provide staff with specialist training in supporting people with autism.

The service used the Care Certificate for employees joining the service who were new to adult social care. The Care Certificate is an introduction to the caring profession and sets out a standard set of skills, knowledge and behaviours that care workers follow in order to provide high quality, compassionate care. All new employees had received training which had included both theory and on the job competency assessments during their induction period and we saw induction documentation in staff files to confirm this. One care worker described how their manager would call regularly during the induction period to ask how they were or if they had any problems. The training coordinator told us that going forwards the service was going to use the Care Certificate modules to address the training needs of existing experienced staff. This meant that the service had an induction process that prepared and supported staff new to care for their roles.

Care workers all told us that they had regular informal one-to-one supervisions with their line managers; this formed part of the 'spot checks' that managers did at people's homes. The registered manager explained that every month, line managers visited five people in their homes at the time the care worker was due to be there. Part of the visit involved asking the care worker how they were, if they had any issues or training needs. We saw that spot checks were documented but the supervision aspect was not always noted. The registered manager said that measures had been put in place to formalise supervision and we saw a timetable for 2016 which listed each care worker with dates for quarterly supervision, as per the company policy.

One care worker said, "We have supervision during the spot checks", another said, "We haven't had proper supervision but we've been told it's coming." This meant care workers had been receiving informal supervision and the service had plans in place to improve and formalise the process.

Care workers told us they received an annual appraisal and we saw from records that this involved an employee self-evaluation and skills rating plus a discussion as to future goals and aspirations. The registered manager said that it was important to identify care workers who wished to progress within the company so that training and support could be provided to help them achieve this. Appraisals also involved discussion about training plans, the outcome of spot checks and the care worker's visit time records. Prior to the meeting, the care worker's line manager also sought feedback about them from the wider team to inform the discussion. We saw that care workers were described in respectful and complimentary terms in appraisal records and that positive feedback was often provided. This meant that the service had an effective appraisal system in place for its staff that focused on personal and professional development.

One of the people we spoke with was assisted with food shopping and meal preparation. We saw that their care plan contained detailed information about the support they needed, and had been updated to remind staff to ask the person in the morning if there was anything they needed defrosting for their evening meal. Each person receiving this type of support could decide what they wanted for their meals and staff would either help them to cook or prepare meals for them. One relative told us, "They give [my relative] food choices", a second relative said, "They make sure [my relative] has food in", and a healthcare professional involved with a person using the service said, "They prompt [name] to eat a healthy diet." Another person who was assisted to shop for food described how staff took them to the supermarket and got them a mobility scooter, so they could access the store and select their own items. We asked them if this was something they enjoyed and they replied, "I love it!" This meant that those being assisted with food shopping and meal preparation received the support they needed.

We asked people if care workers assisted them to book appointments with other healthcare professionals to help maintain their holistic health. The people we spoke with usually managed their own appointments or had families that did this for them. Some people did tell us that care workers had made calls for them if they asked and also accompanied them to healthcare appointments, such as the dentist and outpatients at the hospital. One person told us, "They take me to the hospital for outpatients' appointments. We rearrange my visits so they can take me". A second person said, "They would call the GP if I needed it" and a third person said, "They have called the GP for me before now." A fourth person described how a care worker had taken them to A&E when they were poorly; another care worker had then come to the hospital and stayed with the person for many hours until they could come home again. A fifth person said that they had received an outpatients' appointment the week before our inspection and told their regular care worker about it.

The care worker had liaised with the office for them to rearrange their care visit so that the regular carer could take them to the appointment. The person told us, "I wouldn't be able to go otherwise." A relative told us, "If [my relative] has appointments, they take [them]", and a healthcare professional involved with the care of a person using the service described how they got regular updates on the person's health and well-being. They told us, "They're proactive and get onto issues straightaway", and then added, "If they're not sure about anything, they'll contact me for advice." This meant that the service was flexible and supported people to access healthcare appointments when they needed it and were responsive in terms of people's holistic health.

Good

Is the service caring?

Our findings

We asked people and their relatives if they thought the care workers who supported them were caring and the response was overwhelmingly positive. People we asked told us, "Very caring. I feel that we're friends", "They are very decent", "They've been very good to me. They go the extra mile", "Anything I want they do for me", "Every one of them is so nice and caring", "They don't baby me or talk down to me", and, "They're very, very good." We also asked relatives if they thought the care workers were caring, they told us, "Caring? Oh absolutely. [My relative] likes the carers very much", "They are caring. They try their very best", "Oh very, yes. I'm very happy with them", "Yes. I'm grateful for them", and, "Yes, definitely."

We asked people and their relatives if they thought the care workers promoted people's privacy and dignity; everyone we spoke with said that they did. They told us, "Yes, they always have done", "Yes, they're very respectful", "Yes, they respect it", and, "Oh yes, definitely." We asked care workers to give us examples of how they promoted people's privacy and dignity. One care worker said, "If I was helping a person to wash I would shut the curtains and cover the parts of their body we weren't doing", another care worker said they would close doors to provide privacy. This meant that care workers tried to promote people's privacy and dignity when providing support.

As part of the inspection we wanted to find out whether care workers promoted the independence of the people they supported. We asked care workers if they did this, and if so, how. One care worker told us, "I encourage people to do as much as they can for themselves. Sometimes they just need that bit of encouragement", a second care worker replied, "We have an older client who likes to do their own pots, so we do them together", and a third said, "I ask people to wash themselves if they are able to." A fourth care worker told us, "If I'm doing a lunch call I'll get them to help me prepare lunch and wash up after", and a fifth care worker said, "That's one of the important things we do. I encourage people to do tasks with me." We asked people if the care workers encouraged them to remain independent. One person replied, "They do indeed. Going out with them has helped me considerably", a second person described how they now made cups of tea for themselves and the care worker and explained that the care workers had supported and encouraged them to go out for walks after they had been poorly. This person also said they enjoyed going out shopping with the care workers, they told us, "They let me push the trolley around the supermarket when I was better." We asked people's relatives if they thought the service promoted their independence. They told us, "I think so, yes", "They encourage [name] to do household tasks and manage food", and, "Part of the remit is that they get [my relative] involved." This showed us that care workers tried to promote people's independence by involving them in household tasks and by accompanying them out in the community.

By speaking with the care workers it was apparent that they knew the people they supported very well. They could describe people's likes and dislikes, their preferences, their personal histories and important family members. We asked care workers what they would do if they were asked to support a person usually visited by another member of the team. Every care worker said that they would read the person's care plan but would also call the team leader or another care worker who knew the person to ask them about the person and how they liked to be supported. One care worker told us, "First I would read the client's file and then I would ring one of their usual carers", and a second care worker said, "I'd read the care plan because it's all in there but then ask other carers for advice." Another care worker told us that the service would try to match care workers to people according to people's preferences; they said, "We always ask clients for their preferences, for example, if they prefer male or female carers." We saw in one person's file that they had had more than one change of their regular care worker based on their feedback to the service; the person's wishes had been acted upon each time. Another person told us that they had not got on with a particular carer and had informed one of the managers about this. The service had stopped that carer from coming and had matched the person with a different care worker, who the person was much happier with. A healthcare professional involved with a person using the service told us, "They've been very accommodating in finding a different worker to support [them]." This meant that care workers knew the people they supported very well and the service tried to allocate care workers to people according to their preferences.

We visited Compassionate Care Ltd.'s main office during our inspection. We found that documentation was stored securely such that people's confidentiality was maintained.

Each care file we saw in people's homes contained a detailed service user guide, which included details of how people could access advocacy services, should they need them. We asked the registered manager if any of the people they supported had an advocate and she said they did not as most had relatives that could do this for them. One person we spoke with described how care workers had helped them fill in forms and had spoken on the telephone on their behalf when they needed assistance. They told us, "They advocated for me. They didn't have to do that." The service had links to a local charity which offered advocacy services; the registered manager said that she would ensure people were referred to them if a need arose. This meant that people were provided with details of advocacy services and the registered manager knew of an appropriate advocacy organisation should a person need this type of support.

Requires Improvement

Is the service responsive?

Our findings

We looked at the care files of five people who used the service in the main office and at three other people's in their own homes, with their permission. Each person had a 'summary of care' towards the front of their file. This contained a section which described the person's personality, likes, dislikes and preferences along with details of anything staff should not do when supporting the person. This was followed by a detailed plan of the support provided at each visit the person received. The summary of care was the only care plan each person had, although care files also contained risk assessments and initial assessment documents which care workers were expected to read prior to providing support. The purpose of the summary of care was to summarise a person's support needs into one plan in order to provide care workers with the most important information they needed to know about the person in order to support them effectively and in a person-centred way.

The summaries of care that we read were very detailed and person-centred; however, they were not always comprehensive in terms of each person's identified support needs. For example, in one person's care file we saw that they were assessed as needing support with moving and handling (due to poor mobility) but their summary of care did not include details of this aspect. We also noted that a care worker had alerted the manager about a potential pressure ulcer another person had developed on 19 January 2016 which required observation and the application of creams by care workers. At the time of our inspection nearly four weeks later, the summary of care had not yet been updated to highlight that the person's skin integrity was at risk and there was no other information in their care file relating to skin integrity or pressure area care. This person also needed support to take their medicines, however, their summary of care simply stated 'Prompt meds'; there was no other detail included as to the nature of the support the person required with their medication. A third person that was being supported had a history of mental health problems and yet their summary of care did not contain information on how this had affected the person or what care workers needed to do if any new issues arose. In addition, people diagnosed with dementia had no care plans to tell care workers how the condition affected them or what staff could do to help and support them. This meant that the summary of care sheets and other information used by care workers to understand people's care and support needs were not always holistic in terms of people's identified care needs, or comprehensive. The lack of comprehensive care plans was a breach of Regulation 9 (1) (3) (b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw examples in other care files where the summary of care had been updated and amended as people's support needs changes or they asked for changes to be made. For example, in one person's records it was noted that they had requested help to wash their feet; we saw that their summary of care had been updated to include this. Another person had not got on with a particular care worker and we saw that their summary of care had been updated to include more detail about how the person liked and did not like to be supported by care workers.

All of the people and their relatives that we spoke with agreed that their care plans could be adapted at any time to suit them and they gave examples of when visits had been changed to fit around their appointments and activities. One person told us, "I could change anything in my plan if I wanted to", another person said, "I could change my care plan anytime", and a third said, "If we need to change times they're very amenable." Healthcare professionals involved with people who used the service also gave us positive feedback about the service's responsiveness to people. One told us, "We're in regular contact to discuss care plans and progress", another healthcare professional said, "They give good feedback if there are any issues." This meant that the service was flexible so that care visits could be changed and adapted to suit the needs and wishes of the person.

We found the care files to be concise and filed in a consistent order so that they could be navigated easily. Each file contained assessment documentation relating to the areas of support people needed plus a table showing their preferred hobbies and interests. Assessment documents in people's homes contained a section on life history, where care workers had entered details about people's lives, the jobs they'd done, where they were from and had lived and who the important people in their lives were. We asked people how they had been involved in developing their care plans. On person said, "[The registered manager] did my assessment. I'm very happy with my plan", a second person told us, "[The registered manager] came round to assess me", and a third replied, "I discussed my plans with [a team leader]." We asked people's relatives about their involvement, if any, in planning care for the people who used the service. They told us, "[My relative] was involved. We all sat down and decided together", "They came and did an assessment. [My relative] was involved", and, "We were involved in designing care as a family." This meant that people and their relatives were assessed by either the registered manager or another senior member of staff in order to design their support plans.

We look at the daily records of eight people who used the service. Daily records are the notes written by care workers at the end of their visits to people's homes, which describe the support they have provided. Daily records should make reference to people's care plans and evidence that people have received the support they have asked for. The daily records we saw provided evidence that people were supported in a person- centred way according to the detail in their summary of care documents. We asked four people if their daily records were an accurate description of the support they received from care workers. Three people said that they did, one of them told us, "What they write in my notes is what we did"; the fourth person said they did not read their daily records. This meant that people received the support from care workers that they had asked for and that was described in their daily records.

The service had received two formal complaints in 2015. We read the documentation relating to each of the complaints and the company's complaints policy and could see that the registered manager had resolved each complaint in a timely fashion in accordance with the policy. We asked people and their relatives if they had ever made a complaint about the service. One person described how they had provided feedback; they said they had been concerned when care workers they had not previously met came to support them. The person told us that the service had been very apologetic and now whenever a care worker was allocated whom they did not know, a manager would ring and tell them in advance. The person was happy with this outcome. All of the other people and their relatives we spoke with said they had never made a complaint, but each person or relative said they would complain if they needed to and knew how to do it.

One person told us, "I couldn't complain a bit", another person said, "If there's any problem they come straightaway and sort it out", a third person replied, "I've never made a complaint but I'd speak to [the registered manager] if I did", and a fourth told us that they had also never complained, but said that if they needed to, "I'd speak to the boss (meaning the registered manager)." Relatives we spoke with also said they had never made complaints. They told us, "I'd speak to [team leader's name], or [the assistant manager] or [the registered manager]", "I'd speak to [team leader's name] if I had a problem", "We have a file with contact details and the complaints policy and had to sign a form to say we'd seen it", "I always deal with [the assistant manager]. I have no complaints whatsoever", and, "I've never complained but could speak to [the assistant manager] or [registered manager]." This meant that the registered manager acted upon complaints and feedback and people and their relatives felt they could complain if they needed to and knew how to do it.

Good

Is the service well-led?

Our findings

The service had 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.

We asked people, their relatives and health care professionals involved with people using the service if they thought the service was well managed. Those we spoke with were overwhelmingly positive with their feedback. People told us, "Yes, everyone who comes here is caring and that's why [the registered manager] set it up", "It is well managed. Very efficient. We're very satisfied with them", and, "I do, I've no complaints." We asked relatives the same question, they told us, "It seems to be. They all have rotas and know what they're doing", "Yes, I think so", "Yes. As far as I'm concerned they're very good indeed", and, "Yes, I would say they are." We asked healthcare professionals involved with people who used the service about its management. They told us, "They are excellent", "They're really open and keen to engage. I would recommend them", and, "It does seem to be well-managed."

One of the responsibilities of a registered manager is to report specific incidents to the Care Quality Commission (CQC). Notifiable incidents include safeguarding concerns, police call-outs and serious injuries. We checked the records for these types of incidents and found that two safeguarding concerns had not been reported to us in 2015. Upon further investigation, we found that detailed reports about each incident had been provided to the local authority, but there had been an oversight in terms notifying CQC. We saw that in each case, the lack of notification to CQC had not resulted in an impact on the people involved as the local authority were informed by the registered manager. We discussed this with the registered manager; she apologised for the omission and said that she would re-read the guidance relating to CQC notifications and assured us that it would not happen again in future.

We asked the registered manager how she audited and monitored the service to ensure its safety and quality. She explained that each month 10% of the care files people kept in their homes were spot checked by managers. The unannounced spot check involved checking the care plan to ensure it was up to date, auditing the medicine administration record (if the person was receiving this type of support), observing how the care worker interacted with the person, assessing the care worker's appearance and whether they arrived on time. Spot checks also involved the manager speaking with the person to ask for their feedback on the quality of the service and the content of their care plans. Accidents, incidents and any other concerns were recorded by staff on 'management attention forms', which outlined what had happened or what the care worker's concerns were. The team leader then assessed the form and actioned it accordingly. We checked five of these forms and found that appropriate action had been taken to address the issues raised.

The registered manager told us that they had employed a consultancy company to audit their processes and provide them with advice on improvements to their systems. The company had provided Compassionate Care Ltd with a comprehensive set of new audit procedures for the monitoring of care plans, complaints, medications and incidents and accidents. We saw that the new forms for recording accidents and incidents were already in use and the registered manager was in the process of analysing information for January 2016 to record in the new format. This meant that the service had a system of audit and monitoring in place and was in the process of implementing an improved method of recording and analysing the information gathered.

People and staff received an annual questionnaire to ask for their feedback about various aspects of the service. The last questionnaire had been sent to people in November 2015 and we looked at the responses that had been received. The people who were surveyed were positive about most aspects of the service; some of their comments included, "Friendly, professional and caring", "Does a good job", Happy with the service", "Caring, professional and very kind", and, "Excellent." Some people had said on their questionnaires that did not know how to make a complaint if they needed to. We raised this with the registered manager; she said that she had acted on this feedback and sent out the complaints procedure again to all of the people using the service in December 2015. Our conversations with people and their relatives showed that they did know how to make a complaint, if required. The staff survey in November 2015 had included asking care workers what they liked most about their jobs, they responded, "Feeling fulfilled about helping people", "Being able to help so many vulnerable people", and "I LOVE seeing the smiles on clients' faces knowing we, as a team, have achieved this." Staff reported feeling less satisfied with travelling between visits, a lack of training and not being paid to attend training. We discussed their concerns with the registered manager. She explained that since the survey the service had taken on two training coordinators who had provided more training and were in the process of updating the training plan, and they had started paying care workers mileage for travel between visits and for training. Care workers said they were happy with the changes; one told us, "I'm happy where I am now", and another said, "We're now getting paid mileage." This meant that the registered manager solicited feedback from people and the staff and acted to make improvements when they were required.

Care workers also told us that they were encouraged by the registered manager to suggest improvements to the service. One care worker said they had suggested simplifying the wage slip they received; they told us that this had been actioned and was now much better. Two care workers said they had each suggested printing forms used by the service double-sided rather than single-sided, so that more information could be captured and paper was saved. This had also been taken on board by the registered manager and actioned. A care worker explained how they had asked that visit durations for people being assisted to have a bath were extended to an hour, as in their experience it took this long for a person to have a relaxing and unrushed bath. This had also happened. All the staff we spoke with were positive when asked if they felt able to provide their thoughts and ideas to managers, including the registered manager. They told us, "[The registered manager] says come to me about everything. We try to promote communication with each other", "We have open communication. We adapt and we're flexible. It's a learning curve", "[The registered manager] does listen and always emails back to say she values our opinions", and "If I send ideas [the assistant manager] always gets back to me." This meant that the registered manager encouraged staff to think of ways to improve the service and care workers were keen to get involved with service improvement.

We wanted to find out what the vision and values of the service were, how care workers were told about them and whether they worked in accordance with them. The registered manager told us the vision and values of the service were described to prospective employees at interview and formed part of new starter inductions; she said they were also discussed during team meetings and care workers' supervision sessions. We asked care workers what they thought the vision and values of the service were and they told us, "We want to look after people as if they were our own friends and family and try to keep them in their own homes for as long as possible", "Promoting people's independence for as long as possible and give that high standard", "Make people feel they're worthwhile and have a purpose", and, "It's about what I would want for my own mum." Care workers also confirmed that vision and values were discussed as part of their regular team meetings. This meant that care workers understood what the service's vision and values were and were reminded of them regularly.

The registered manager went out of her way to show staff that they were valued employees. Care workers told us about letters they had received from her stating her appreciation of their efforts; we saw one of these letters that had been sent to a relatively new recruit, praising them for their positive attitude and hard work. The service had also implemented an employee of the quarter scheme to coincide with team meetings, whereby care workers nominated each other in recognition of their hard work or support. At the last team meeting, three care workers had received money and a bottle of champagne each. The registered manager organised a Christmas party for staff to attend at a local hotel and paid a contribution towards care workers' tickets so that they could be offered to staff at a significant discount. One care worker said of the registered manager, "[The registered manager] is lovely to work for and I have thanked her for employing me", and then added, "She does everything she can for the clients and the staff". Another care worker said, "If you want a meeting with [the registered manager] or [director] they'll text to ask when I'm free. They're very flexible and this is why I've stayed." A care worker who'd received a letter of appreciation from the registered manager said, "It made me feel good, yeah." This meant that the registered manager showed appreciation for the staff and that they felt like valued employees.

The service worked in partnership with other businesses and organisations. A week before the inspection the registered manager and director had secured an investor who was to work with the service to develop the use of technology and improve staff access to training. The first step in this new arrangement was an ideas workshop for all staff to be held in March 2016; the registered manager hoped that together as a service they could identify areas for improvement and consider solutions. The service had a nominated individual. Nominated individuals are usually the main point of contact between an organisation and CQC and supervise the way regulated activities are undertaken. The service's nominated individual was in the process of organising a 'care hub' with other local domiciliary care agencies with the purpose of sharing training, ideas and best practice. It was also hoped that a shared bank of care workers could be created to facilitate the cover of staff shortages or sickness. The service was also part of the 'My-Choice Marketplace', a consortium of independent organisations who provide care to people who either self-fund or receive a personal budget from the local authority. The collaboration was established and chaired by a not-for-profit organisation and overseen by the local clinical commissioning group and services which sign up agree to abide by a code of conduct. The three healthcare professionals we spoke with all agreed that the service worked collaboratively with them to meet the needs of the people they were involved with. One of the healthcare professionals said of working with the service, "I've been very pleased, it's been very positive", another said, "They've always been really good. I would recommend them", and a third told us, "They were very supportive", and added, "I would use them again with no hesitation." This meant that the service worked in partnership in order to grow and improve and to meet the needs of the people.

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 9 HSCA RA Regulations 2014 Person- centred care People's care plans were not always comprehensive in terms of their identified care and support needs. Regulation 9 (1) and (3)(b)

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent The service did not comply with the requirements of the Mental Capacity Act 2005. Regulation 11 (1) and (3)