Directsupport4u Ltd

Directsupport4ultd

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection visit took place on 25 May 2016. We gave the provider 48 hours' notice of our inspection visit because the service is a home care agency and the acting manager is often out of the office supporting staff or providing care. We needed to be sure they would be in.

Directsupport4u Ltd is a home care agency supporting people who live in their own homes in central and north Warwickshire. At the time of our inspection 36 people were supported with personal care.

It is a condition of registration that the service has a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. The service had not had a registered manager since June 2015. The provider told us that two staff were in the process of applying to be registered manager one of who was the current acting manager.

People who used the service were safe when they received care and support, though two people who no longer used the service contacted us before our inspection visit to say they were not comfortable with care workers who were sent to support them. The provider had a recruitment procedure under which all the required pre-employment checks were carried out. Those checks were made with a view to ensuring that only staff suited to work for the service were recruited. However, after recruitment interviews no record was made why people offered positions were considered suitable.

People's care plans included risk assessments of activities associated with their personal care routines. The risk assessments provided information for care workers that enabled them to support people safely but without restricting people's independence.

Enough suitably skilled and knowledgeable staff were deployed to meet the needs of the people who used the service. Staff arranging home care visits were knowledgeable about people's needs. They sought to allocate care workers with the relevant skills and knowledge to support people with particular needs and preferences.

Care workers were trained in how to support people with their medicines. A set of medication administration records we looked at had been retrospectively completed which meant we could not be sure that people had actually received their medicines. Care workers did not always complete medicines administration charts or report gaps in those charts. This meant the provider was not able to check quickly whether a person had taken their medicines.

People were cared for and supported by care workers who had the relevant training and support to understand their needs. Relatives of people who used the service at the time of our inspection were mainly complimentary about the skills of care workers. Care workers were supported through supervision, appraisal

and a training plan that was being implemented at the time of our inspection.

The acting manager understood their responsibilities under the Mental Capacity Act (MCA) 2005. A care worker we spoke with had awareness of the MCA. They understood that people had to be presumed to have mental capacity to make decisions about their care and that their capacity could change from day to day.

Care workers either prepared meals for people or supported people to make their meals according to the level of support people required.

Care workers received training to help them understand about medical conditions people lived with. They supported people to access health services when they needed them.

Care workers were caring. People were supported by the same care workers most of the time. Most people received home care visits close to the times they expected. However, the provider was not monitoring how well they were performing against those criteria.

People who used the service were involved in decisions about their care and support. They received the information they needed about the service and about their care and support. People told us they were always treated with dignity and respect, though three people told us that their preference for female care workers was not always met.

People contributed to the assessment of their needs and to reviews of their care plans. People's care plans were centred on their individual needs. People knew how to raise concerns if they felt they had needed to.

People who used the service, their relatives and staff had opportunities to be involved in the development of the service.

The provider had arrangements for monitoring the quality of the service. However, those arrangements did not monitor how well the service was performing in relation to things that were important to people using the service. Those arrangements were in the process of being improved at the time of our inspection. The acting manager carried out monitoring activities to gather people's views and experience of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

The provider's recruitment procedures did not always record why a person was considered suitable to work for the service.

People were supported to take their medicines. Record keeping of medicines administration was not always timely.

Staff understood and practised their responsibilities for protecting people from abuse and avoidable harm.

Is the service effective?

Good

The service was effective.

People were supported by staff who mostly had the right skills and knowledge to meet their needs.

Staff were supported through supervision, appraisal and training that enabled them to understand and provide for people's needs.

Staff understood their responsibilities under the Mental Capacity Act 2005.

When people required it, they were supported with their meals. Staff supported people to access health services when they needed them.

Is the service caring?

Good

The service was caring.

People were involved in decisions about their care and support.

Care workers treated people with dignity and respect.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People mainly received care and support that was centred on their personal and individual needs. Some people's preferences for female care workers were not always met.

People knew how to make complaints and raise concerns and most people told us their concerns were acted upon. People were not advised where they could refer their complaint if they were not satisfied with the response to it.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The service had not had a registered manager since June 2015. The provider had not acted on a legal requirement to complete a Provider Information Return.

The provider had arrangements for monitoring the quality of part of the service but not aspects of the service people said were important to them.

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Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection visit took place on 25 May 2016 and was announced. The provider was given 48 hours' notice because the service is a small home care agency and we needed to be sure staff would be at the office.

The inspection team consisted of an inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. They did not return a PIR and we took this into account when we made the judgements in this report.

Before our inspection visit we spoke with two people who no longer used the service who had contacted the Care Quality Commission to share concerns about their experience of the service. During our inspection we tried to speak by telephone with ten people using the service but they preferred that we spoke with their relatives. We were able to speak with seven relatives. We looked at three people's care plans and associated records. We reviewed information about the support that staff received through training and appraisal. We looked at three staff recruitment files to see how the provider operated their recruitment procedures and at records associated with the provider's monitoring of the quality of the service.

We spoke with the acting manager, the operations manager, the director and a care worker.

We contacted the local authority who paid for the care of some of the people using the service. We also contacted Healthwatch who are the local consumer champion for people using adult social care services to see if they had feedback about the service.

Requires Improvement

Is the service safe?

Our findings

Every relative we spoke with told us they felt the service was safe. Relatives of people using the service told us a reason they felt the service was safe was that home care visits were mostly at times they expected. Most people told us they were happy with the timings of visits. Although some people said that care workers were not always on time, they said this had not caused them problems. However one relative told us, "There have been a couple of incidents of carers not turning up. I have rung the office and they haven't been aware. They have been apologetic and offered to send someone but to be honest I have declined as it is easier to see to [person's name] myself than wait". The operations manager monitored whether care workers had arrived at people's homes using a `log-in' system. If a care worker had not arrived within 15 minutes of a scheduled time or if they had not logged-in a visit, an alert was generated in the office. This meant the operations manager could find out where a care worker was, inform the person waiting for a care worker and, if necessary, arrange for another care worker to make the visit. A relative told us, "They can be up to half an hour late but they will usually let us know". The way home care visits were arranged, monitored and `alerts' responded to meant that people could feel safe because the risk of them not receiving a home care visit was minimal.

Two people who no longer used the service contacted us before our inspection visit to share concerns about their experience of the service. They told us that whilst they usually felt safe when they were being supported they felt uncomfortable at times. One person said this was because a male care worker had been sent to support them despite their having requested only female care workers. Another person told us they were made to feel uncomfortable by the behaviour of a care worker. The provider now informed people if only male care workers were available so they could decide if they wanted a male care worker to visit or make alternative arrangements.
People felt safer when they knew which care worker would be visiting them. One relative told us they felt anxious about not knowing. They told us, "I worry, as does [person's name], about who is coming. Sometimes it is the first thing he asks me in a morning. I like to know who is walking through the door. They [the service] started off sending the same carers then we seemed to get random people. I spoke to them about it and we have more of a routine now". This showed that the provider listened to people's concerns about feeling safe.

People were advised about how to stay safe in their homes. This happened when the acting manager visited people to make an assessment of their needs when they began to use the service. The acting manager carried out a risk assessment of the person's home environment and advised them about how to stay safe in their home. For example, telling people about potential hazards in their home. Some people had `key safes' which meant that care workers could lock people's doors after home care visits. People using the service could feel secure because care workers left the property locked after a home care visit.

Care workers wore gloves and aprons whilst carrying out personal care routines. The protective equipment was supplied by the provider. A relative told us, "We have a big pile of stuff [gloves and aprons] here for them to use. It is only hygienic". People using the service could therefore be confident that care workers took the right precautions to provide care with proper regard for hygiene.

Care workers knew how to identify and respond to signs of abuse. They knew about the provider's procedures for reporting suspected or actual abuse. They had received training in safeguarding people from abuse or avoidable harm. A care worker we spoke with knew about the different types of abuse they were required to report. They told us they were confident that if they raised any concerns with the acting manager they would be taken seriously. They told us, "I'm confident about reporting any concerns".

People's care plans had risk assessments of activities associated with their personal care routines. The risk assessments were detailed. Risks were assessed according to a person's dependency levels for a wide range of their daily needs; for example their mobility, their dietary needs, health and care routines. A care worker told us that they referred to people's care plans and risk assessments to read how people could be supported safely. They told us, "I read a person's care plan and care records so I know how to support them safely". Relatives told us that care workers supported people safely when helping them to stand from a seating position or vice versa. A relative said, "The staff are very good. They support [person's name] out of the chair to use the walker and into the wheelchair if needed".

The provider had procedures for care workers to report incidents and accidents that occurred during home care visits. The care worker we spoke with was aware of those procedures. We saw that care workers had used those procedures and that reports were reviewed by the acting manager to identify any learning.

The provider operated a recruitment procedure. When we looked at recruitment documentation we saw that the required pre-employment checks were carried out. These included Disclosure Barring Service (DBS) checks. DBS checks help to keep those people who are known to pose a risk to people using Care Quality Commission (CQC) registered services out of the workforce. The provider's recruitment procedures included a system for assessing a person's suitability to work for the service. However, in the three recruitment files we looked no record was made why people who were offered positions were considered suitable which meant the provider had not followed their recruitment procedures.

At the time of our inspection the provider employed 12 care workers. All had received relevant training to understand the needs of people they supported. There were enough care workers to cover the home care visits that people required. However, most care workers were male which meant that at times people were not supported by female care workers who they preferred. A relative told us, "One of the carers they sent was male despite our request for only ladies. I did speak to the company about it and they did send more females. It is not a massive issue and it seems to be working well at the moment". The provider had informed people when a male care worker rather than a preferred female care worker had been allocated a home care visit. A relative told us, "They did have to send a male on one occasion but they did ask and we agreed". There had been a small number of occasions when the choice for a person using the service was between agreeing to a male care worker or cancelling a home care visit. The provider was in the process of recruiting more staff with an aim of a more balanced workforce to be able to meet people's preferences.

Care workers supported people to take their medicines at the right times. They either reminded people when to take their medicines or handed their medicine to the person and stayed with them until it was taken. Care worker's competence to support people with their medicines was assessed by the acting manager every three to six months. We saw that those assessments were thorough and that on occasions care workers were reminded about safe and correct practice. We found that not all care workers completed medicines administration records (MARs). One MARs had not been completed on some days to show whether medicines had been administered. That had been identified by an acting manager and discussed with the responsible care worker. The care worker made retrospective entries on the MARs but these provided no reliable assurance that the person had their medicines on the days in question. We also found that care workers were not reporting gaps in MARs records. For example, a care worker completing a MARs

record on 14 February 2016 did not report gaps in the record for 12 and 13 February 2016 to an acting manager. This meant there was no timely check to establish whether a person had their medicines or not. We saw from medicines audits that had been carried out that record keeping on MARs was a recurring issue. The provider was aware of this and was addressing through supervision meetings with care workers who were not completing MARs correctly.

Good

Is the service effective?

Our findings

Relatives of people who used the service told us they felt that most care workers had the right skills and knowledge to meet their individual needs. A relative told us, "I think they are well trained. I can trust that they are getting on with their job". Another relative told us why they thought a care worker was "excellent". They said, "The carer managed to get [person's name] in the shower after many weeks where they refused the support from other carers. I spoke to the carer and she was brilliant, she achieved what the others had backed away from". Another relative highlighted that some staff were more skilled than others. They told us, "Some (staff) are better at things than others. There is one person who lacked either confidence or competence. He seemed to be scared of dealing with [person's name]. I spoke to them at the office and they didn't send him again". Another relative had more confidence in care workers who regularly visited than in less regular care workers. They told us, "If it is a new carer I need to be here. [Person's name] has complex needs and I like to make sure the staff understand this".

Care workers received training that was relevant and helped equip them with skills and knowledge to carry out their roles. All new care workers had a week long induction which introduced them to the service, its aims and objectives and policies and procedures. They `shadowed' an experienced care worker until acting manager was satisfied they could support people unsupervised.

The acting manager was developing a training plan at the time of our inspection. This consisted of a range of 40 accredited e-learning training modules. The service's operations manager and acting manager supported care workers to progress through the training modules. They delivered `classroom' training in areas where practical training, for example, supporting people with their mobility, allowed care workers to practice safe techniques. Training covered health conditions people lived with. A care worker told us, "My training has helped me to do my job".

All care workers were provided with an employee handbook that explained their responsibilities and referred them to the provider's policies. They received support through regular supervision meetings with the acting manager. A care worker told us, "My supervision meetings have been helpful with my development. It's a good service to work for."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. 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. Any applications must be made to the Court of Protection. We checked whether the service was working within the principles of the MCA.

All of the people who used the service were presumed to have mental capacity to make their own decisions about the care and support they received. That was the correct position to take, because under the MCA a person must be presumed to have mental capacity unless there is evidence to the contrary. The acting

manager demonstrated a good understanding of the MCA when we spoke with them. A care worker we spoke with showed good awareness. They understood that a person's mental capacity to make decisions could vary from day to day. They described how they provided people they supported with enough information for them to make informed decisions and they respected these even though they placed a person at risk.

None of the people using the service had specific nutritional needs that they required support with. Support from care workers was limited to preparing meals or supporting people to make their meals. Relatives we spoke with told us they made meals for people using the service and some left instructions for care workers about how to heat the meals. They told us that the quality of support people using the service received with their meals varied depending on which care workers visited. A relative explained, "I like to know who is coming. I sometimes go out and leave food for [person's name] depending on who (care worker) is coming. I will leave out sandwiches as they (the care workers) are all different and sometimes they get mixed up. For instance, one care worker is really good and will cook a lovely meal, but others do not seem to be able to understand what I need them to do, so I try to make life easy".

Care workers supported people with their health needs. They were able to do that because they had received training and education about medical conditions people who used the service lived with. A relative told us, "[Person's name] condition means that they can have a fit at any time. The staff are really good; they know exactly what to do and if it goes on over a certain length of time they will call an ambulance". People's care plans included information about people's health needs and how they wanted to be supported with them. This meant that care workers were able to identify and respond to signs of changes in a person's health. They reported concerns to the acting manager who then contacted the person and if necessary arranged support from the relevant health services including emergency services. Times of home care visits were changed to accommodate health care appointments people had arranged to attend.

Good

Is the service caring?

Our findings

Relatives we spoke with told us that care workers were caring. Most had got to know the care workers through conversing with them. One relative said, "Some staff are very chatty, others less so. But I think that's because they don't know what to say". Another person told us, "The carers are all very polite and we have a bit of banter. They listen to [person's name] needs and choices and will pick up on little things". Another person said, "The carers are very caring they encourage him to do what he can. I know them all now and trust them".

The provider sought to develop caring relations with people from when they began to use the service. When a person's needs were first assessed a key part of the assessment was to find out precisely how they wanted to be supported. A care worker told us they were introduced to the person they were allocated to support so that they could get to know them. Care workers tried to develop a caring relationship so that people feel they mattered to them. A relative told us, "[Person's name) has a great relationship with the carers she has. They get up to all sorts of things". Another said, "We have a laugh and a joke they are all very pleasant. They support both of us really and always ask if there is anything else they can do before they go".

People's wishes and preferences about the gender of care workers who supported them were not always met. Two people who made it clear to the service that they wanted to be supported by female care workers sometimes had male care workers support them. One person, who no longer used the service, was distressed by this. Relatives we spoke with could not recall being given a choice of male or female care worker, although two told us they had been asked if they objected to a male care worker. Both said they had requested female carers. Sixty per cent of the care workers employed by the service were male which impacted on the provider's ability to consistently meet people's preferences. The provider was attempting to have more balance in their workforce through continuous recruitment.

The provider understood it mattered to people that they were supported by regular care workers. Relatives of people using the service told us they had a preference for the same care workers to provide care and support. It was important to them that they knew which care worker(s) would be visiting. One told us, "I do like the same people. We used to get different staff but it has settled down a bit now. It is important for me to know who is coming so I don't have to keep repeating myself about where things are and I can trust they know what they are doing with [person using service]". When home care visits were planned the operations manager took care to try and ensure that people were supported by the regular care workers. People with more complex needs were supported by the same care workers. A person who had `24 hour 7 days a week' care was supported by a team of care workers. A relative told us, "[Person's name] has two carers who work alternate weeks. There are other people who come in to cover breaks [person's name] has got to know them." We found that people were supported by regular care workers most of the time.

People using the service had opportunities to be involved in decisions about their care and support. The acting manager visited people every three months to discuss their care and support. They had recently begun making telephone calls to people in between visits to seek people views and discuss any changes they wanted. For example, when people asked for home care visits to be made at different times their wishes

were acted upon. People had access to their care plans in their home and they could read the notes that care workers made at each visit. A relative we spoke with told us they and the person using the service were involved in developing the care plan and others told us they had seen a care plan. People were provided with an information brochure about the service. This included information about the aims and objectives of the service, how people could contact the service and how they could make a complaint. People were also given a CQC leaflet about the standards they had a right to expect of a home care agency. This was useful information as it helped them to identify if their experience of the service was below the fundamental standards of care.

Care workers respected people's dignity and privacy when they provided care and support. A person using the service told us, "The carers are all very good, very kind". The provider had a `code of values' which included the statement `Ensure dignity is recognised and respected at all times'. A care worker told us, "We were taught that we must respect people's privacy and dignity when we provide personal care. I make sure I close doors, draw curtains and that a person is not disturbed or interrupted when I provide care. I respect people choices and decisions".

Requires Improvement

Is the service responsive?

Our findings

People contributed to the assessment of their needs and their care plans confirmed this. The care plans included details about the care and support people wanted. With very few exceptions, people received care and support that was centred on their needs and preferences. The exceptions occurred when the service sent male care workers contrary to people's preferences. Where the provider felt they could not meet the needs of people using the service they worked with their social workers and the social services department of a local authority to support them to find an alternative service.

Relatives of people using the service told us what was important to them. They told us they wanted care workers to make home care visits at times they had agreed with the service and that they preferred to have the same care workers as often as possible. They wanted care workers to be knowledgeable about people needs and how they wanted to be supported. The service had mainly met people's expectations. A relative told us, "We don't get the same carers but they are all nice. They don't always let us know if they are going to be late but I am so grateful for their help. We are not constrained to time frames". Relatives told us that the same care workers usually made home care visits. One explained how that had been a benefit to a person using the service. They told us, "[Person's name] has a great relationship with her carers". Relatives also said that they were pleased with the quality of care their family members had received. Two people no longer using the service were critical of the care they experienced on occasion either because of an individual care worker's attitude or because a male care worker was sent despite their preference for a female care worker.

Most of the people using the service were referred to the service by local authority social services who paid for their care. The provider worked closely with the local authority to meet people needs. We saw in one person's records that the provider had contacted the local authority on nine occasions to advise that they could not meet a person's needs. This called into question how effective the provider's own assessment of the person's needs was before they began to use the service. However, it also showed that the provider was acting responsibly in informing the local authority it could not meet a person's needs.

Most people received care and support that was tailored to their needs. People's preferences about how they received their care and support were usually met. In part this was due to how home care visits were arranged. Home care visits were planned up to a month in advance by the operations manager who had in-depth knowledge about people's preferences and individual care worker's skills. They matched people's needs and preferences with the skills, experience, knowledge and other characteristics or care workers. For example, a person living with a medical condition was supported only by care workers who had training about it. They also matched care workers with people so that they could be supported with their hobbies and interests. For example, people were supported to attend a gymnasium or to go swimming by care workers who also enjoyed those activities. Another person using the service enjoyed doing puzzles. Their relative told us, "The carers sit and do puzzles and interact well with [person's name]." A relative of one of those people told us that support had been an important factor in the person using the service having a trusting relationship with the care worker. The operations manager used their knowledge to ensure as often as possible that people were supported by the same care workers. They were developing computer software they used to maximise effective scheduling of home care visits which was centred on people's preferences.

Relatives told us that although the same care workers usually made home care visits, they would have preferred to be informed in advance of who would be visiting to give them peace of mind and a sense of security. We discussed this with provider who told us they would consider how people could be sent a rota of which care workers had been allocated.

Care workers made written records at the end of their visits to record how they had supported a person. Those records were reviewed by the acting manager. They cross referenced the records with information in people's care plans to check whether the records provided assurance that people were supported in line with their care plans. We looked at a selection of records and found that they provided such assurance. The acting manager had identified that some care workers needed support with the quality of their notes and was supporting them with this.

People's views were listened to. Relatives of people using the service told us that the office was easy to contact and staff were polite and would deal with their queries efficiently. One relative said, "I had a really good chat to them a couple of weeks ago. I told them I would move if necessary. I like to know who is coming and said they needed to go back to sending us the same people". However, a relative who told us they contacted the office to point out an error (two care workers arrived within an hour of each other) told us, "I wasn't making a complaint; I was simply trying to explain the organisation seemed to have gone adrift. I was quite put out at the way she spoke to me. Her attitude was all wrong". People no longer using the service told us the staff they had spoken with at the office were "curt". We saw in a reply to a complaint that the provider had written that a relative had `unreal expectations of times and what is expected of a home care agency'. That response to the complaint was incompatible with the provider's statement of purpose which said that the aim of the service was `to deliver person centred and outcome based services'. The outcome to the complaint was to give the person using the service 28 days' notice of termination of the care package, rather than attempt to resolve points that were disputed. Although the provider's complaints procedure advised people they could refer their complaint to the local government ombudsman if they were not satisfied with the response to a complaint, the complaint response letters did not. We discussed this with the provider who told us they would add that information to complaints response letters.

Requires Improvement

Is the service well-led?

Our findings

People using the service were involved in developing the service insofar as their views about the care and support they received were sought. This happened during reviews of their care plans and telephone monitoring calls. People's views were acted upon, for example changes were made to the times home care visits were made. At the time of our inspection the provider was considering how to seek the views of people using the service and their relatives through an annual satisfaction survey.

Care workers had opportunities to be involved in the development of the service through supervision meetings. These took place either in the provider's office or as a continuation of an observation visit by the acting manager whilst care workers were undertaking care calls. The provider was looking at different ways to provide staff with opportunities to provide feedback about what they thought of the service and how it could be improved.

Staff were supported to raise concerns they had about the service, including what they considered to be unsafe care practice by colleagues. They knew they could raise concerns directly with the acting manager, operations manager or the director. A care worker we spoke with told us they were confident about raising concerns. They also knew they could raise concerns directly with the local authority adult safeguarding team or the CQC.

A care worker we spoke with told us they felt that the service was well managed. Relatives we spoke with shared that view. One told us, "They seem to be a well organised company. We've never had an issue when care has not been delivered". Out of the seven relatives we spoke with, five told us they would definitely recommend the service to others. Two relatives were less confident. One told us, "If they carry on the way they have for the last two weeks I would recommend them but if we go back to sending random carers again I wouldn't". Their comment showed that the provider listened to their views.

It is a condition of the service's registration with CQC that it has a registered manager. However, the service had not had a registered manager since June 2015. We were told that the acting manager and another person were in the early stages of applying to be a registered manager, but no record of that was made available to us. CQC have no record of applications for a person to be a registered manager. Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. There is a regulatory requirement for a provider to respond to a request to complete a PIR. On the day of our inspection the provider found our request for a PIR and acknowledged they had not completed it.

The provider had a statement of purpose that set out their aims and objectives `to deliver person centred and outcome based services'. We found that the provider had no clearly defined procedure for assessing and monitoring the quality of the service. There were no procedures for identifying improvements to people's experience of the service. For example, the provider knew from people's feedback that punctuality of home care visits and being supported by regular care workers or, in some cases, female care workers, was

important to them. However, there was no monitoring of how well the service was performing in relation to what mattered to people or whether performance was improving or not. The system used by the provider was capable of generating information about the service's performance. We discussed this with the provider who told us that the system they used would be better utilised.

Monitoring activity that did take place included reviews of people's care plans and checks of the quality of care worker's daily records and MARs charts. The provider monitored the conduct and care practice of care workers. This was through observation of care practice at monitoring visits. Care workers were given feedback from the observation and actions were taken by the acting manager to support staff to improve their practice. The provider was planning to supplement their monitoring activity with an annual satisfaction survey.