Kelly Park Limited

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Inspection report

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Date of inspection visit:
09 October 2018
08 November 2018

Date of publication:
19 December 2018

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

This inspection took place on 8 October and 9 November 2018. The provider was given 24 hours' notice to make sure someone would be at the registered office to meet us.

This service is a domiciliary care agency. It provides personal care to people living in their own houses. It provides a service to older adults, younger adults and children. The service covers a large area which includes County Durham, Gateshead and South Tyneside and is managed from an office located in Consett. At the time of this inspection 336 people were using the service.

Not everyone using Kelly Park Limited received regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also consider any wider social care provided.

We last inspected this service in August and September 2017 when it was rated 'requires improvement'. At the last inspection we made two recommendations. These were that the provider reviews staffing levels and does an in-depth analysis of call times once the electronic monitoring system is embedded and that the provider reviews the competency of all staff in relation to moving and positioning so that they can be confident staff have the necessary skills to support people safely.

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.

Some people and relatives told us that their care workers were not always consistent or arrived as expected. Documentation confirmed that some people's care was completed either early or late and care workers did not always stay for as long as was agreed.

Staff supported people to stay safe in their own home. Assessments of risks people faced were in place for care workers to follow. These were regularly updated to reflect any changes in people's care needs.

Staff understood their responsibilities with regards to protecting people from harm. Safeguarding incidents had been responded to in-line with the service's procedures. Staff recruitment was safe.

Medicines were well managed. Medicine administration records were completed accurately. Competency checks were conducted with care workers to ensure they remained competent with this task. The company provided care workers with personal protective equipment (PPE) and reminded staff to use this appropriately.

Staff completed an induction programme before providing care and completed additional training at

regular intervals. Induction training included training to meet the needs of people using the service but some of this was not routinely updated. Staff received regular supervisions, observations and an annual appraisal. We made a recommendation that specialist training be reviewed and updated periodically to ensure staff have up to date knowledge and skills in these areas.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People told us that care workers made meals of their choice and supported them appropriately with eating and drinking. External health and social care professionals were involved with people's care to ensure their ongoing welfare.

People, relatives and professionals told us all staff were caring, kind and respectful. People said care workers upheld their dignity and privacy. Care plans contained person-centred information.

People's needs were assessed, planned and reviewed to ensure they received care which met their needs. Care plans reflected people's social needs and the service supported these needs where commissioned to do so.

Complaints and concerns were not always responded to in a timely way or to the satisfaction of the complainant. New complaints policies and procedures had been implemented to address this and very recent improvements had been made.

We received mixed feedback about the management of the service from people and relatives. Staff we spoke with, or received feedback from, had however noted improvements to the way the service was managed and delivered. This included the way visits were scheduled and having more senior staff available to support them on a daily basis.

Feedback was sought about the service from people, relatives and care workers through visiting people at home, satisfaction surveys and staff meetings.

Improvements had been made to the quality assurance system but this continued to not fully address concerns raised over the delivery of the service, such as the timeliness and consistency of calls. Audits were not always robust in identifying issues and setting actions to address these.

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

Some people told us they did not always feel safe because their visits were early or late and they did not always know who was coming and were not always informed when things changed.

People were protected against the risks associated with the unsafe use and management of medicines.

Accidents and incidents were appropriately recorded and investigated; risk assessments were in place and staff had been trained in how to protect vulnerable adults.

Is the service effective?

Good

Staff told us they felt better supported by the service. Staff were given an induction, some of which was practical training, ongoing training, supervision and spot checks. We made a recommendation about ensuring that specialist training was regularly reviewed.

Staff understood how the mental capacity act applied to people's care and how to support people in their decision making.

People's nutritional needs were assessed and people were given the appropriate levels of support with meal preparation, eating and drinking.

Is the service caring?

Good

People, relatives and professionals told us that care workers were caring and supported them with dignity and respect.

People were supported to be an independent as possible.

People felt they were involved in decisions about their care.

Is the service responsive?

Requires Improvement

As at the previous inspection, people had mixed views about the way their concerns and complaints were dealt with. Historically concerns had not always been responded to in a timely way or to

the complainant's satisfaction. More recently improvements had been made to the way concerns were addressed.

Personalised care plans were in place that were reviewed to ensure the service met people's needs.

People's social needs were recorded and met where this was a requirement of the service. Staff also identified where people were at risk of social isolation and acted on any concerns they had.

Is the service well-led?

Requires Improvement

Although most of the feedback we received about the service was positive, some people felt the organisation of the service could be improved.

Audits and quality assurance systems had improved but still failed to robustly identify and address all concerns, specifically those about visit times and the consistency of the visits.

Staff told us that the service had improved and there was additional support for them which made it easier for them to do their job. They received timely and relevant information about the people they supported and best practice about their roles.

Kelly Park Limited

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.

Inspection site visit activity started on 8 October 2018 and ended on 9 November 2018. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. The inspection included visits to the service's office and telephone calls to people who used the service, their relatives and professionals who were involved with the service. We visited the office location on 8 October and 9 November 2018 to see the manager and office staff; and to review care records and policies and procedures. The first day of the inspection was carried out by two adult social care inspectors and the last day was carried out by one adult social care inspector.

On 10,11 and 12 October 2018, two experts by experience conducted telephone interviews with 48 people who were receiving care in their own homes. We also spoke with 20 relatives to gather their views about the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Prior to the inspection we reviewed all the information we held about Kelly Park Limited including any statutory notifications that the provider had sent us and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.
We also used information the provider sent us in the Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. In addition, we contacted Durham County Council local authority commissioning team and adult safeguarding team to obtain their feedback about the service. We contacted the local Healthwatch team and obtained information from the local authority commissioners for the service and the local authority safeguarding team. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care

services in England. We also spoke with three health or social care professionals by telephone.

At the site visits, we spoke with the provider, registered manager, a risk assessor, care co-ordinator, three senior carers and a care worker. We asked care workers to complete a questionnaire and received 23 responses. We reviewed a range of care records and the records kept regarding the management of the service. This included looking at seven people's care records, nine people's visits records, medicine administration records, three staff files and quality assurance documentation.

Requires Improvement

Is the service safe?

Our findings

At the last inspection we found that the service was not always safe and rated it 'requires improvement'. At this inspection, although we found improvements in some areas we also saw that people continued to have concerns about the timings of their care visits and that recommendations from the last inspection had not been fully implemented. We therefore found that the service continued to not always be safe and again rated it as 'requires improvement'.

At the last inspection we recommended that the provider review staffing levels and do an in-depth analysis of call times once the electronic monitoring system was embedded. At this inspection we found that there had been more senior staff employed and received feedback from staff that this had improved the way their visits were organised. This meant that staff had less travel time and could attend visits more promptly. Staff also stated that care co-ordinator gave them greater support and issues that might delay calls were dealt with more effectively.

Despite the call monitoring system having been in use since the last inspection there was still no way to analyse the overall benefit of this in terms of reducing early or late visits. The provider could not provide evidence about how many visits were being delivered on time or within the 15 minutes tolerance set out as acceptable in the service's policy. People were advised that staff may sometimes attend up to 15 minutes early or late and visit running outside of these times were logged and addressed as they occurred.

Staff confirmed that they were not always able to attend visits within 15 minutes of the agreed start times and they were not always able to stay the full length of time. Staff also told us, however, that they felt there were less late visits. There was a mixed response from the people and relatives consulted when asked if staff arrived on time, and some told us they were not always informed if the carer was going to be late. People's comments included: "Yes. They come in on time to tie in with the district nurses, it works well", "The main carer, I can set the clock by her, but if carers have to travel they can get held up", "Sometimes if there is an emergency they can be late. They will let me know and stops me wondering, it happens less than once a week", "They are alright in the mornings but not at the night time, the times change and they are late at night.", "They are up to an hour late and they have not turned up at all, at least twice recently. They say they will look into it, but they don't get back to you" and, "They have been two hours late and they don't ring to let [person] know."

People and relatives had mixed views about the consistency of the staff that supported them. Some people had a very reliable team of staff but others commented on the high staff turnover and the fact they did not always know the staff visiting them well. A small number of people commented that it was hard to build relationships as staff the staff that supported them changed frequently. The registered manager and staff told us these issues were being resolved with better planning of rotas and better staff retention.

Staff told us they did not get time allocated to travel between visits but did get time for breaks. The staff we spoke with told us that they were more likely to be able to take breaks now and this was an improvement. We checked visit records for nine people and found that in five of these people's records there were visits

that were over 15 minutes early or late. On three people's records we found examples of visits that had been over 45 minutes early or late. We also received feedback from the local authority stating they had made recommendations to the provider because visits they sampled at a recent monitoring visit were shorter than commissioned and late visits were identified. Feedback from two social care professionals we spoke with was that visit times continued to be an issue.

We spoke with the provider and manager about this and they agreed that it was not always possible for visits to happen on time but they felt that this had significantly improved. They had requested analysis from the call-monitoring system from the company who managed this system but that this was not yet available. There were plans in development to implement a back-up rota, which would ensure there were always staff available to cover visits in the event of an emergency. They felt this would significantly reduce delays in the service.

People and relatives we spoke with told us that, other than in relation the timing and consistency of visits, staff provided a service that made them feel safe and that safety measures were in place. For example, some told us: "I definitely feel safe, never had any qualms about them [care workers], being in the house", "I felt quite safe, I found them very friendly.", "Yes, I feel safe. I have got to know the carers, they are kind and understanding" and "Very much safe, recently I had two falls. The carers hardly leave me alone, they check I am alright, see me up upstairs and make sure I have a cup tea."

Recruitment procedures were in place to ensure suitable staff were employed. Applicants completed an application form in which they set out their experience, skills and employment history. Two references were sought and a Disclosure and Barring Service check was carried out before staff were employed. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and minimises the risk of unsuitable people working with children and vulnerable adults. Staff told us they felt that improvements to the recruitment process, such as more robust checks and more office staff to manage recruitment, meant that more suitable staff were being employed and this was having a positive effect on retaining staff and the quality of the service.

We saw that the provider had policies and procedures explaining how staff should respond to whistleblowing and safeguarding concerns. Staff told us they knew how to recognise abuse, what action to take to and how to report their concerns. Staff had received training in safeguarding and told us they were confident that the management would act on any concerns they raised. The service had referred to the local authority as required and completed investigations into concerns raised. Where lesson had been learnt from safeguarding these had been shared with staff via meetings. We also saw that staff had received additional training or supervision in response to concerns.

Appropriate arrangements were in place for the safe administration of medicines. We saw that this had improved and that if errors were made there were processes in place to take immediate actions to reduce the risk of them happening again. Medicines were monitored via the electronic monitoring system and office-based staff counter checked that each medicine was administered in a timely way and inputted onto the system. We checked medicine administration records which showed people had been given their medicines safely and at the right times. Staff had received training in medicines administration and had spot checks to ensure they remained competent to administer medicines. We found one occasion where appropriate codes were not being used when medicine was being left out for the person to take themselves. This was being done with the authority of health professionals and the agreement of the person. The manager addressed this with staff during our inspection.

People who used the service had risk assessments that described potential risk, the safeguards in place to reduce the risk and action taken to mitigate the risks to the health, safety and welfare of people. These covered areas such as people's home environment, nutrition, moving and handling, behaviour and mental health. We found that these managed risks in the least restrictive way and were regularly reviewed. Accidents and incidents were monitored for any trends and learning from these was used to inform safe working practices.

Staff protected people from the risk of infection by following the provider's infection control procedures. We saw spot checks monitored if staff used personal protective equipment (PPE), such as gloves and aprons when delivering care. People we spoke with told us that PPE was used most of the time but there were the odd occasions when staff neglected to do this. One person said, "[Care workers] just started to wear gloves, aprons, sometimes they don't." This had been identified in some of the service's own audits and had been addressed with staff.

Good

Is the service effective?

Our findings

At the last inspection we found that the service was not always effective and rated it 'requires improvement'. At this inspection, we found that the service had improved and therefore rated it as 'good' in this area.

People and their relatives told us they felt they received care from competent staff. Comments from people included: "they do things well," "they are nice and efficient. It is very good service," "fully confident in them, quite happy with the care we receive," "we have quite a bit of apparatus, I have a mattress and a bed bath. They know how to use them" and "I know they have completed training and know what they are doing."

Most people told us staff were familiar and knowledgeable about their needs and had the experience to deliver their care effectively. Comments from people included: "When a new one comes they come in twos to show them what to do," "they (carers) do online courses and shadow when they first come," "some carers shadow as part of their training. I couldn't do with a stranger, without them coming once or twice to shadow to make sure they had an idea of what to do." Ten people, however, told us that staff were sometimes new to them and, therefore were not always familiar with their needs. Staff told us occasions where they were visiting someone without first shadowing an experienced member of staff had reduced recently.

All staff we spoke with, or who responded to our questionnaire, told us they were provided with training that enabled them to do their job and meet people's needs. One staff member told us, "We have regular programmes, I've just done infection control. We do mandatory training each year. We can ask to go on any training. I'm on doing PEG feeding training, someone is coming on board who has a PEG." A PEG (Percutaneous Endoscopic Gastrostomy) is a way of introducing food, fluids and medicines directly into the stomach.

Staff had training in a range of subjects covering: moving and handling, health and safety, record keeping, food hygiene, first aid, safeguarding, mental capacity, confidentiality, medicines, privacy and dignity and equality and diversity. Staff also had training specific to the needs of people using the service such as epilepsy and diabetes awareness, however these were only delivered as part of the one day induction training and not provided again unless by staff request. Other training classed by the provider as mandatory, was regularly updated and reviewed to ensure staff had current knowledge.

We recommend that specialist training be reviewed and updated periodically to ensure staff have up to date knowledge and skills in these areas.

Staff received regular supervisions and an annual appraisal. Supervisions and appraisals are one to one meetings between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Staff received spot checks, where they were observed in people's homes completing a range of care tasks, these included feedback from the person receiving the service. We reviewed a selection of these records and found feedback to be positive about care workers.

All new staff completed an induction, which include some practical training such as moving and handling.

This was an improvement from the last inspection where it was identified that staff did not receive practical training. Staff who were new to care completed the 'care certificate', a recognised induction standard for care workers.

People's needs were assessed before they started using the service, where possible. Where services started at short notice or in emergencies people were assessed when the service started. A detailed assessment was carried out that recorded people's individual needs. These assessments and ongoing assessment of people's needs were used to develop support plans.

Where people received support from staff with meal preparation they told us that they were happy with the level of support they received. Care plans stated where people had specific nutritional or dietary requirements that staff needed to be aware of. Care workers had training around nutrition and hydration and were aware of the need to encourage good food and fluid intake. One person told us, "They make sure I have fluids." A relative told us, "The carer will prompt her to eat and spoon feed if necessary."

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 with appropriate legal authority. In care homes, and some hospitals, this is usually through MCA application procedures called the Deprivation of Liberty Safeguards (DoLS). We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty had the appropriate legal authority and were being met.

The service had sought consent from people for the care and support they were provided and for the sharing of information and photography. Where people were unable to provide consent, this was recorded.

Some people had Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) forms in place. DNACPR means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). Records were up to date and showed people and family members had been involved in the decision-making process. Care workers had training in CPR as part of their induction training and confirmed they had received this when we spoke with them.

The service involved social work or health care professionals where they had concerns about someone wellbeing and asked for onward referrals to be made if needed. Care records contained evidence of referrals to and advice from external specialists including GPs, district nurses, dietitians and SALT (speech and language therapists). People told us, "On one or two occasions they suggested I should get the doctor, I rang the doctor, I was happy with that," "if I need a doctor they will ring them for me. They will book an appointment at the chiropodist for me" and "yes, if I need an appointment they can ring the surgery and they have rung the dentist for me."

Good

Is the service caring?

Our findings

People and relatives we spoke with told us they thought staff were caring. People's comments included, "They [staff] are brilliant and very kind and do anything for me," "They are lovely I can't do without them" and "They are very caring, and very friendly." Relatives told us, "On the whole we do have a regular first class carer who my relative likes and she is good. The carer sits and talks to her throughout the visit, including in the shower" and "The care from one carer is excellent and superb."

People told us they had good relationships with the staff that supported them. For example, people told us, "They are very jolly, we have a good laugh," "We have rapport, we can have a laugh" and, "They treat me like their grandma." People told us staff guided them through tasks and gave clear explanations of what they were doing. One person said, "They are caring and family orientated. They don't just do what they have to do, they talk to me first."

We spoke with three health or social care professionals. They all told us they thought care workers were caring. One profession old us, "Staff are lovely...a couple have walked to calls in the snow to make sure people got their calls."

People told us that staff communicated with them and listened to them when they were providing care. For example, people told us: "They listen to my stories," "They listen and are reassuring and give me a hug if I need one. They feel more like friends than carers" and "If I get fed up they listen to me and they understand my memories go back years and I like talking about the past. They listen to me as if they are interested in me." Staff told us they sometime took their breaks with people who used the service if the person wanted them to do this. This meant they could spend more time talking with the person and building relationships.

Care records demonstrated the provider promoted dignified and respectful care practices to staff. People and relatives explained that staff treated them with respect. A relative told us, "The carer will come out and close the bathroom door." Another relative said, "If they get [person] up, they leave the curtains closed until they are ready, then open them up and the same at night time."

People were supported to be as independent as possible. One person told us, "They know me and know what I can and can't do." Another person and their relative gave us examples of how they were supported to be independent. Another person told us, "I have heard them [staff] say 'you need to do things for yourself'" and "Oh yes, they do, I walk through from the bathroom to the bedroom and they walk behind to make sure I don't fall."

People were supported to access advocacy services when needed. Advocates help to ensure that people's views and preferences are heard.

Requires Improvement

Is the service responsive?

Our findings

At the previous inspection we found that the service was not always responsive and rated it 'requires improvement'. At this inspection we found that the service continued to have shortfalls in this area and again rated it 'requires improvement'.

We received mixed feedback about the way the service managed complaints. People and relatives told us that not all concerns were being resolved they would wish and some people told us they had not received a response to concerns they had raised. Comments included, "It seems quite good. Everything I have brought up they resolved," "I would just ring the office up. I've not needed to as not had any problems," "Sometimes they were late, they sorted this out" , "There isn't any organisation, I have raised concerns and complaints and they have not been addressed," and "No, they don't take concerns or complaints seriously, because I have made a number of them about staff who turn up with not the right skills to deal with the complex needs of [family member], to needing two staff which is in care plan, one staff member turns up then waits fifteen minutes for the other staff to turn up, it's always inconsistent. My complaints have never been resolved."

Another person told us that they paid for thirty minutes care and only received twenty minutes and received no feedback to the complaint that they made. Earlier in the year both CQC and the local authority had been involved in complaints that had been escalated to them because the complainant did not feel the service had responded appropriately or to their satisfaction. CQC had made several requests for the outcome of several historic complaints as these had not been initially supplied in a timely manner.

We spoke to the registered manager about the feedback from people and relatives about complaints. They told us the provider had reviewed the policies and procedures for investigating complaints, the new version of which had been shared with people who used the service and was on the provider's website. We saw that more recent concerns and complaints, even of a minor nature, were being logged and immediate action taken. The satisfaction of the complainant with the outcome was also logged and any lessons learnt shared within the service. Feedback from the local authority and the provider was that this had reduced the number of formal complaints. Requests from CQC were also being dealt with promptly. The registered manager told us the service was being proactive in dealing with concerns before they escalated to complaints.

The way that care files were written had been improved since the previous inspection. Care files we reviewed were person centred and had been reviewed regularly. Person centred means the person was at the centre of any care or support plans and their individual wishes, needs and choices are considered. People's histories, backgrounds, interests, likes and dislikes were captured, as were any relevant details people wanted to share about their cultural, sexual or spiritual identity and how staff could support them and protect them from discrimination.

An initial assessment was carried out with people when they first enquired about support or were referred by the local authority. Staff visited people at home to gather information about the level of people's individual care needs. An environmental assessment was completed regarding any risks in the home such as

utilities, fire, appliances, garden areas and pets. People's communication needs were assessed and the level and type of assistance they needed to communicate because of a sensory loss or disability was documented. Once agreed and signed a copy of the care plan was given to people to keep at home.

Care plans contained information about people's needs including medical history and health needs, mobility, daily routine, emotional support and social needs. Care plans contained information about generic risks and in some cases, a separate risk assessment had been completed for specific risks individuals faced. Care plans included details about what was important to the person, such as; preference in relation to the way they liked to dress and their preference around their diet. People told us generally where they expressed a preference for staff, such as the gender of staff to support them, this was respected, we were given two examples from people of where they had been unhappy with the care worker who attended as this had not been their preference. The registered manager told us that the people's preferences were respected as far as was possible and we discussed an example of where alternative care workers had been offered to try to find an alternative that suited the person.

The service had a process for introducing staff to people they were working with for the first time. New staff shadowed a member of staff experienced in that person's care. Feedback from staff was that this did not always happen but that this was happening much more regularly since the employment of care co-ordinators to oversee the allocation of staff to new visits. Care co-ordinators also completed care visits so they were familiar with people's care needs.

Staff told us they linked with professionals where they identified people were at risk of social isolation. One staff member told us, "If we've noticed them becoming isolated we inform them of what is going on in the local area. Carers report if someone's mobility has changed and we report this back to social services."

Checks were made to ensure that people were happy with the way their care was delivered. Recent checks showed that additional information was being collected from people to ensure their personal preferences and life histories were up to date and as comprehensive as possible. Reviews were held with the person, and their relatives if they chose. People's choices were documented.

Staff had received training on how to care for someone at the end of their life. We saw that people's wishes about end of life care had been discussed with them and recorded. There was evidence that the service worked with health and social care professionals to deliver end of life care.

Requires Improvement

Is the service well-led?

Our findings

At our previous inspection in August and September 2017 we found the service was not always well-led and was rated 'Requires Improvement' in this area. This was because people were not always receiving information about which home care workers would visit in advance, staff were arriving too early or too late and the service was not always communicating when home care workers were late. Although staff and management told us these areas were improving we still received mixed feedback from people, relatives and professionals, including comments to suggest improvement was still required in these areas. We therefore rated this service as 'Requires Improvement' again as the changes made had not embedded sufficiently to ensure a consistent service was being delivered.

The service had a registered manager. We received mainly positive feedback about the management with most people telling us they were happy with the management of the service. There were also people and relatives we spoke with who felt that the management did not listen to them and had not responded to their concerns. Social care and health professionals we spoke with told us they also received mixed feedback on the service and the management of the service, with visits times and consistency of staff still being reported as an issue. One professionals told us, "I can't see any improvement. The times of visits and consistency means most to people, it doesn't always happen." We saw that the way concerns were dealt with was improving but improvements had been recent and need to be sustained over time

We found that there was a commitment to make on-going improvements in the service. We saw that there was an improved quality assurance system that was evolving to meet the needs of the service and improvements suggested by external organisations. This included regular audits, spot checks and reviews. Audits covered all areas of the service such as staffing, medicines management and complaints. Spot checks included a photograph of the carer taken during the spot check, observations of care being delivered including any moving and handling, medicines administration, use of PPE and feedback from the supervisor and the person receiving the service.

The service used an electronic call monitoring system which allowed office staff to monitor visits in real time and make any calls or adjustments required to rotas. Staff told us that they were in frequent contact with the office and were contacted prior to visits and again if they were running late. All the care documentation, audits, checks, rotas and new information for staff were processed through the electronic system and staff could access updates remotely and immediately. Incident forms, medicine administration records, food and fluid intake charts were also completed electronically. The registered manager told us, "The electronic call monitoring system is brilliant for monitoring medicines administration. The care co-ordinator does the daily medicines alerts which is a daily audit."

We saw that the electronic system had been improved over time to better meet the needs of the service and to ensure all of people's care was delivered as planned. Each person's care tasks were accessed via staff mobile telephones, and each task was ticked as completed otherwise the system alerted the office. Initially they found there were too many alerts coming through as each task was broken down into different components which was not always necessary. The registered manager told us they reviewed the task list

and streamlined the tasks so that the alerts were meaningful and managing them was achievable.

We found however that, as at the last inspection, some monitoring systems were not robust and there was no analysis of the timeliness or length of calls. Spot checks looked at if the carer was on time for the visit being checked but did not review this for any other visits. Audits completed looked at written visit record sheets against the electronic system but did not check if calls were completed as commissioned and agreed with people. It was not clear from the audits what information was being checked in relation to care records with checks stating 'satisfactory' but not detailing what had been checked. Although the electronic system could generate a report on this data this was not something the service was in receipt of yet and this still needed further development. The management spoke with us about their plans to improve these systems and to develop a standby rota but these were in development and there was no documented plan for their completion.

In two recent audits from a sample viewed we saw that the people had expressed they were not happy with the times of their calls changing or the number of carers who visited them. Nothing was documented to explain how these concerns would be addressed.

People's views were frequently collected through quality assurance survey's and spot checks. The frequency that people were consulted had been improved to ensure the management were more in touch with what people thought about the service. The provider told us, "Customer surveys are now done every four weeks so that any issues can be rectified more quickly…each senior carer had responsibility for completing these surveys." The management told us this feedback had been very positive and saw this to be the case from a sample of records we looked at. There had not yet been any analysis of the 2018 responses to demonstrate if these had significantly improved from 2017's responses.

Practice issues were discussed with staff through regular staff meetings. These included the importance of clear and accurate record keeping. Best practice was shared with staff, as were any lessons learnt from incidents in the service. Guidance and best practice, such as from NICE (National Institute for Health and Care Excellence, who provide evidence-based guidance on health and care) and the Department of Health, was also shared with staff directly via the electronic system and could be accessed by staff as needed.

The registered manager attended a local provider forum and was part of a group of offering support to other providers around areas such as recruitment and training. Two staff recently attended an infection control event on dehydration and catheter care, changes were to be implemented in the service based on this learning.

Services that provide health and social care to people are required to inform the Commission of important events that happen in the service in the form of a 'notification'. The provider had made timely notifications to the Commission when required in relation to significant events that had occurred.