London Community Home Care Limited

London Community Homecare Ltd

Inspection report

225 Marsh Wall
First Floor, Office 4
London
E14 9FW

Tel: 02074260409
Website: www.lchc.co.uk

Date of inspection visit:
17 May 2016
20 May 2016

Date of publication:
17 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected London Community Homecare Limited on 17 and 20 May 2016, the inspection was unannounced. We gave the provider notice to ensure the key people we needed to speak with were available. Our last inspection took place on the 13 November 2013 and we found that the provider was meeting all of the regulations that we checked.

London Community Homecare Limited provides personal care and support for people living in their own homes. At the time of the inspection there were 68 people using the service.

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.

Care plans and the care provided to people demonstrated person centred care was the focus of care delivery. Advanced care wishes were written in people's care plans on how people wished to be supported.

The provider carried throughout risk assessments in people's homes. However, risk assessments had not always been reviewed when there were changes to people's health and welfare.

Safeguarding concerns were reported in a timely manner and the provider took preventative measures to minimise further concerns. The provider adapted their call times to meet the requirements of the people that used the service.

Some aspects of the recruitment procedures were not thoroughly carried out to assess the suitability of the staff employed. Staff had completed a thorough induction, training and supervision that was reflective of the needs of people that used the service

There was a suitable number of staff deployed to meet the needs of the people who used the service.

Staff had a very good understanding of the Mental Capacity Act (MCA) 2005. The provider was worked within the principles of the MCA. People told us they were consulted and asked for their consent to the care they received.

The provider did not follow the appropriate systems to ensure medicines were managed safely. There were errors in the daily recording of medicines. Staff had received the appropriate medicines training.

People were supported with their nutritional and dietary requirements and this was recorded in their care plans.

Changes in people's healthcare needs were identified by care workers and immediate intervention was sought.

People told us staff were caring and friendly and were considered be like part of the family. People and their relatives told us care workers respected their privacy and dignity when supporting them with personal care.

People told us they received person centred care that was responsive to their needs. Communication with people was highlighted in people's care plans as being an important aspect of their well-being.

There was a free phone number for people to contact the head office so people's concerns could be recorded and monitored to improve the way the service delivered care.

People gave positive views about the service and explained the service was easily accessible.

Staff told us the registered manager was supportive and knowledgeable about the care the service delivered to people in their homes.

Benchmarking was used by the provider to set new standards of practice. The provider had good working relationships with external stakeholders.

We found two breaches of regulations relating to the management of risks to people's health and welfare. We have also made a recommendation about recording quality audits for the service. You can see what action we asked the provider to take at the back of the full version of this report.

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

Elements of the service was not always safe.

People's medicines were not always managed safely. Staff had completed the required mandatory medicines training.

Risks assessments had not been updated to reflect changes to people's health and well-being.

Certain aspects of the recruitment procedures were not used effectively to ensure the suitability of care workers.

People told us they were supported by the same care staff and felt safe. Staff knew the correct action to take to keep people safe from harm.

Is the service effective?

Good

The service was effective.

Staff had completed an induction, training and supervision to ensure they provided effective care and treatment to people.

People's consent was sought regarding their care and support needs in accordance with the Mental Capacity Act (MCA) 2005.

Staff were trained in safe nutrition and hydration. People's nutritional needs were recorded in their care records.

People told us staff supported them to access healthcare services.

Is the service caring?

Good

The service was caring.

People and their relatives told us staff were caring, respectful and polite when providing them with care. Staff were recognised and valued for any outstanding contributions they had made to people's care.

Compliment and gratitude letters were received from people and

their relatives to thank staff for the care they received.

Staff were respectful of people's cultural and spiritual needs. People were provided with information on accessible formats, to help people understand the care available to them.

Advanced care wishes were written in people's care plans on how people wished to be supported.

Is the service responsive?

Good

The service was responsive.

Staff demonstrated a commitment to providing high quality person centred care. The service placed great importance on people maintaining their independence and choose how they would like to be supported.

People told us the service was accessible and were kept informed of any changes to their care provision.

Concerns and complaints were recorded and monitored to improve the way the service delivered care.

Is the service well-led?

Good

The service was well-led.

Staff spoke positively about the registered manager and were confident if they had any concerns they would be resolved.

The provider kept up to date with best practice through membership with professional organisations.

Systems were in place to obtain people's views about the care and support provided to them.

London Community Homecare 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.

We visited London Community Homecare Ltd on 17 and 20 May 2016 to undertake an inspection of the service. The inspection was unannounced. 48 hours' notice of the inspection was given because the registered manager could be out of the office supporting staff or visiting people in their homes. We needed to be sure that they would be in.

The inspection team consisted of two inspectors on the first day of the visit, and one inspector on the second day. An expert by experience made phone calls to people who used the service to seek their views on the care and support the service provided. 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, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give us some key information about the service, what the service does well and improvements they plan to make. We checked information that the Care Quality Commission (CQC) held about the service including the PIR, previous inspection reports and notifications sent to CQC by the provider. The notifications provided us with information about changes to the service and any significant concerns reported by the provider.

During our inspection we spoke with eight people who used the service and four relatives. We contacted the local authority and Healthwatch and spoke with one health and social care professional to gather information and obtain their views regarding the service. Healthwatch are a consumer group that gathers

and represents the views of the public about health and social care. We did not receive a response from Healthwatch.

We viewed the records in relation to eight people's care including their support plans, risk assessments, daily records and their medicines records. We also spoke with nine care workers, the care coordinator, the recruitment consultant, the team leader and the registered manager.

We also looked at records relating to the management of the service. These included eight staff recruitment and training records, minutes of meetings with staff, quality assurance audits, information packs, statement of purpose, staff rotas and a selection of the provider's policies and procedures.

Requires Improvement

Is the service safe?

Our findings

Risks to people's health care needs were not always reviewed to ensure people received safe care. There was a procedure to identify and manage risks associated with people's care. Before people started using the service an initial assessment of their care needs had been carried out by the local authority or the clinical commissioning groups (CCGs) to determine how many hours of support were required to meet their needs. The CCGs are clinically led NHS organisations responsible for the planning and purchasing of health care services for their local area.

Some of the risk factors that were assessed related to people's daily routine, mobility, medicines, social stimulation, physical health and well-being. In one file, where a person had difficulties with eating, they were assessed by a health professional and a strict diet plan was put in place for care workers to follow. The service also carried out a risk assessment on the external and internal environment of the person's home. For example, they checked to see if people had smoke detectors and how care workers could access people's homes. Staff who completed risk assessments with people had been trained to complete the assessments.

This information was then used to produce a care plan and risk assessment around the person's care needs. The care plan contained details about the level of support that was required and information about any health conditions the person had. The information in these documents included brief guidance for care workers in how to manage risks to people. Records confirmed that risk assessments had been completed however we saw information did not always correlate with their care needs. For example, one person had been assessed as being at a high risk from falls, but the moving and handling risk assessment recorded a low risk. There had been four falls recorded over an eight month period however the risk assessment had not been updated. Another person had a financial protection plan in place and had been allocated an appointee to manage their finances. We saw records that showed were the provider had contacted with the local authority regarding their finances but the care plan and risk assessment had not been updated to reflect this. This showed that care plans and risk assessments were not consistently updated when there were significant changes to people's needs.

The registered manager advised the care coordinator act on this immediately and updated the care plan and risk assessment for the person who had a financial appointee. They also arranged a visit to the person's home to ensure the person read and agreed to the updated plans.

People told us how they were supported with their medicines. Relatives also told us they were satisfied with the support received, one relative said "The carers give medicines morning and evening. If [my family member] has refused, they will phone me or the office to try and sort out the difficulties. Communication is good with problems like that."

However, despite the positive feedback we found that one person was not always effectively supported to ensure that their medicines were managed safely. Care workers were prompting one person to take Controlled Drugs (CD's) however we found that there were inaccuracies recorded on the MAR. The MAR

record showed that the CD had been given but not signed by the care worker and the time the CD was offered was not recorded. There was no record in the person's communication sheet/daily logs that showed a controlled drug had been taken. This meant the provider could not be assured that staff were safely supporting people to take their medicines. We spoke to the registered manager who told us the CD was offered as a pain relief for the person as a PRN (as required) medicines. We looked at the providers' policy regarding CD's and PRN medicines which stated the dose and time must be recorded on the MARs. The registered manager acknowledged the error and told us she was attending a medicines course the following day to update her certificate and agreed to clarify with the care workers the correct procedures for supporting people with CDs and PRN medicines.

The above issues relate to a breach of regulation 12 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Some people were supported with their medicines as part of the overall care package they received and their care plans contained information about their medicines. This included the name of the medicines and how they were dispensed, whether any relatives or health care professionals were assisting with the medicines or if people didn't require any support with this. This demonstrated that the provider took into account people's ability to self-administer medicines and the level of support they required. Care workers had received training to administer medicines safely and records we looked at confirmed this. Staff who were responsible for prompting people with their medicines had received training which was refreshed every two years. We looked at the training records which showed all the staff had received this training and had regular medicines competency assessments.

We looked at a sample of two people's medicine administration records (MAR's) over a period of two months. We saw they were appropriately completed and reasons given for why medicines were not given.

Criminal records checks were carried out on all the staff and the provider had systems in place to verify if staff were suitable to work with the people who used the service. The appropriate background checks had been sought before staff began work. Records included application forms, job descriptions, two references from previous employers and identification checks. Contracts of employment and the Working Time Directive (WTD) were signed by staff to show they fully understood the responsibilities of their roles. The WTD places a limit on weekly working hours, which staff must not exceed. Care workers employed were assessed by the use of interview questionnaires which were based on a scoring system which were used when making recruitment decisions. This tool is also used to provide care workers with feedback after an interview. However we found the scores had not been completed in some of the care workers interview questionnaires. This meant that good recruitment practices were not always followed and evidenced when assessing applicants for their roles as care workers. This was a breach of regulation 19 of the Health and Social Care Act 2008 (Regulated activities) Regulation 2014.

Where people had mobility needs staff used a key safe to gain access to their home. This was recorded in people's care plans. There was a procedure in place to inform staff of what to do if people did not answer the door. We spoke with staff that had a good understanding of the emergency procedures in the event they were unable to gain access to people's homes. We looked at the incident records and saw the registered manager had taken action on these and informed the Care Quality Commission (CQC) when this was appropriate. We saw in one record that a care worker had followed the key holding procedure, and the police were contacted when the person did not answer the door. However the registered manager did not inform the CQC of the incident that was reported to the police. The registered manager must ensure that all

notifications that are reported to and investigated by the police are submitted to the CQC.

People told us they felt safe with the service they received. One person told us, "The agency are wonderful they are like my family, they are very important to me."

We spoke with staff who told us they been supported with the appropriate training in safeguarding and had an understanding of who they would report to if they had concerns about a person's welfare. The provider had procedures in place to protect people from harm. The whistleblowing procedure was displayed on the office notice board and gave clear guidance on who concerns should be reported to, such as the CQC and other public organisations.

There was an easy read safeguarding policy so the information was accessible and understood by people who used the service. Any outcomes following safeguarding concerns showed that the agreed preventative measures had been put in place and the guidelines had been followed by staff to minimise further harm to people. For example, we saw records where a safeguarding concern had occurred regarding a person's finances in the home. Following this the provider had produced an easy read guide for inform people what care workers can and cannot do when supporting people with their finances in their homes. The guide was in the process of being sent to people who used the service. The registered manger took part in a safeguarding adults champion sub group and information received by the CQC demonstrated the registered manager was committed to working in partnership with the local authorities' safeguarding teams.

People told us that staff arrived on time and stayed for the agreed length of time and were flexible in their approach to the support hours requested. One person told us, "The [care worker] is very good. I'm used to her/him. The carer always stays, and hasn't got time to go early," and another said, "Sometimes if I've had to change times they're easy to contact." Other people we spoke with told us there was a consistency of the same staff supporting them in their homes and when the regular carer was not available, another carer was readily available. One person told us, "One carer is enough I have the same carer," and a relative commented, "My [family member] has the same carers. Morning and evening, same carers. It's different at lunchtime but always the same. Sometimes my [family member] has different carers because of covering but not often. I'm always at home." Another relative explained that their family member was also happy with the care workers who visited during the weekends and reported, "My [family member] has four carers in total. Two [care workers] my [family member] sees very frequently and is very relaxed with them. My [family member] is also happy with the ones at the weekend as well."

There was a delayed and missed visits procedure and care workers explained to us the procedure for reporting late and missed visits. The registered manager told us they spoke to people regarding the times they would like the care workers to visit them, and we saw this had been changed and updated in people's care plans. We looked at the roster system and found there was a sufficient number of staff to meet people's needs. Staff told us they had enough travel time between each visit and we saw that the service had placed the majority of care workers with people based on the use of similar postcodes to minimise long distance travel. Records we viewed showed were people had cancelled visits the office staff had informed the local authority or the CCG immediately.

People told us they were supported by care workers to do their shopping. One person explained they received the right change and receipts and said, "They do the shopping; they put everything in a notebook." Daily records showed that people's finances were accurately logged and recorded which demonstrated that people's finances were protected. We saw a sample of completed financial transaction forms when care workers handled people's finances for food and shopping. We saw the amount that was given, the amount spent and the change returned. It was signed and dated by the care worker and the person and records were

returned to the office to be checked. We looked through samples of the past five months and saw they had been checked and receipts matched the records. There was a gift and signing of legal documents procedure which outlined the processes staff must follow when giving or receiving gifts and staff told us they had read and understood the policy.

An on call system was in place for people and staff to contact in the event of any concerns, or if they required advice and guidance. There was a daily handover of this to the office staff to ensure people had received safe care. Care workers carried their identification badges which included their name and photograph so people could identify the care worker who would be helping them in their homes.

Good

Is the service effective?

Our findings

People and their relatives told us they received care from staff that were able to carry out their roles to the best of their abilities. One person said, "I appreciate the [care workers] because I have the care I need." One relative explained the care workers knew what their family member wanted and commented, "They know because they're used to my [family member]."

Staff told us they received support to meet their identified training needs to ensure they were able to carry out their roles effectively. Before new care workers supported people, shadowing opportunities and handovers were arranged to ensure they knew how to meet people's needs.

We saw records that showed staff had received medicines assessments every six months, even if they were not currently supporting people with medicines. The manager said, "It is important to be refreshed about something as important as understanding medicines." One observation highlighted that the care worker was not confident in administering medicines and they were given extra training and their next assessment was brought forward.

Staff undertook a 12 week comprehensive induction called the Care Certificate standards. The Care Certificate is a set of minimum standards that should be covered as part of induction training of new care workers and aims to equip staff with the knowledge and skills to provide safe care. This included privacy and dignity, nutrition and hydration, equality and diversity and work in a person centred way. There were records of training staff had completed such as medicines, infection control and communication. The office staff had also completed various training courses such as fire training, intensive interaction, dementia, first aid, and ulcer prevention and infection control. There was a training room in the office and we saw that the office staff had completed train the trainer in moving and handling to ensure the carer workers competencies were assessed regularly. We also saw that there were records of regular staff meetings, spot checks, supervisions and appraisals for all the staff. Staff were supported with their on-going professional development and had completed or were in the process of completing a recognised national vocational qualification.

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.

We checked whether the service was working within the principles of the MCA. We saw records in care plans that showed best interests meetings had taken place and that mental capacity assessments had been completed. There was a best interest's checklist form for staff to follow. Where best interest decisions were being made people, their relatives and healthcare professionals had been involved in these discussions. In one care plan a financial assessment had been undertaken and an appointee had been chosen to help

manage the financial affairs of that person. In other people's files we saw a capacity assessment was completed by health professionals for consent to a civil partnership and for a person who was living with dementia.

Where people were living with dementia the registered manager and the care workers told us the 'type' of dementia people were diagnosed with and how this could affect their capacity to make decisions and we saw in on person's file were it was written to 'encourage the person to choose'.

Initial assessments made by the CCG indicated if people had lasting power of attorney (LPA) of people's finances or health and welfare, however at times the information was not fully completed by the organisation referring the information. For example, in one record we saw the information regarding an LPA was blank but the providers care plan showed the person had an LPA. An LPA is a legal document to appoint a person help make decisions on another person's behalf. We discussed this with the registered manager who immediately contacted the health professional to obtain the correct information. We spoke to staff and found they had a good understanding of the principles of the MCA and confirmed they had attended MCA training.

People and their relatives told us they were consulted and asked for their consent to the care they received. One person said, "The [care worker] always asks whether things are OK. She/he never does anything without asking." A relative told us, "It's great, the [care worker] is polite and that. They always ask what my [family member] wants." Care plans and risk assessments were signed to indicate people had agreed to the care and support they received.

People required support with meal preparation and in some cases, support whilst eating. People's dietary preferences, allergies, medical and cultural needs were recorded in their care plans along with the level of staff support needed. We looked at a sample of daily log sheets which confirmed people were eating the foods that they wanted to. This showed that care workers had read and understood the care plan and were aware of the specific dietary requirements of the people they supported. Care plans also advised care workers to ensure food was served at the correct temperature and to make sure the cooker was switched off. We did see one care folder which showed that a person had the same meal three times a day, for a number of weeks. Even though this food was highlighted as a preferred food, there was no evidence in the daily logs that care workers had encouraged the person to eat any other foods. We spoke with the registered manager about this and she told us she would ensure the care workers record that other healthier options had been offered to show that people were supported to maintain a balanced diet. Another person had been assessed as being at risk of malnutrition. Contact had been made with a dietician and advice was sought on specific foods and the appropriate diet plans.

People we spoke with told us they were supported by health and social care professionals to maintain good health. One person told us, "If I needed a doctor, my daughter would phone, but my carer would do that. The chemist delivers my medicines."

We viewed people's care plans and found they included the details of involvement with health and social care professionals. There were discharge summary sheets in people's care plans that outlined the details of people's hospital stay so care workers could understand and provide the correct and safe care to people. Relatives and staff were included in the reviews of people's health and support needs and this also included health professionals input into the training care workers on how to move and position a person safely. For example, after a person was discharged from hospital the occupational therapist and district nurse gave demonstrations to the care workers of best practice on directed transfer techniques.

Changes in peoples need were identified by care workers and immediate intervention was sought. One senior care worker told us, "I was not happy when I saw a person developing a bed sore so I raised the alarm." Care plans included observations of skin integrity and one written record advised carers to ensure the pressure mattress was working for a person who had a pressure ulcer. How people would like to be supported with their personal care was written in detail such as oral hygiene and foot care. One person who was at risk of falls showed that incidents had been reported to health and social care professionals, such as social workers and occupational therapists, who were contacted to carry out the relevant assessments and to request more support. Another person was supported to access the district nurse and the follow up information was recorded in their file. One care worker had concerns about a person's skin condition when they were carrying out personal care. An on call report form was filled out and contact was made with the office to liaise with the district nurse.

We saw records that showed when people's health deteriorated referrals were made to increase the amount of support required. One person's mobility started to cause concerns for the care worker. We saw records that showed contact had been made and increased support had been authorised to ensure the person was safe when receiving personal care.

Good

Is the service caring?

Our findings

People told us staff were caring and friendly and were considered be like part of the family. One person told us, "Very friendly. No complaints whatsoever. The [care worker] is like part of the family," and a relative said, "My [family member] has more medical needs rather than caring, but we still need the service because they're good company. As far as the caring goes they're a great bunch."

The providers' philosophy of care read 'Carers and support workers will respect and maintain dignity, privacy and confidentiality as well as consider a person's individuality' and we saw this was followed. Regular meetings were held with the care workers and showed there was a good attendance. Meetings of the meeting we viewed noted that care workers behaviour towards people should be polite, caring and respectful at all times. In one's person care plan we saw it was written for the care worker to consider respect dignity and privacy when assisting in personal care.

People and their relatives told us care workers respected their privacy and dignity when supporting them with personal care. One person said, "They close the door and, you know, do everything," and a relative commented, "My [family member] has problems washing. They'll sit outside the door and keep talking to her/him, and only go in when my [family member] asks."

Staff were respectful of people's cultural and spiritual needs. For example, we saw for one person an advocate of the same gender was sought by the local authority to provide both translation and cultural advice and this was included in the person's care plan. In other people's care plans details of people's religious and cultural beliefs were documented and where people had no religious beliefs care workers were respectful of this. One relative told us, "Sometimes they ask if my [family member] prayed or wants to pray." A person who used the service told us their care worker was from their country of origin which meant the care worker understood their cultural needs.

Care plans demonstrated person centred care was the focus of delivery rather than being task led and were able to meet people's individual needs and were involved in the decisions about their care. Care workers told us they read people's care plans before they delivered their care. One person confirmed, "They look in the folder to know what to do," and a relative told us, "The carers read the care plan. As they've got used to my [family members] and her/his needs I've found they do that little bit extra. For instance, my [family member] has a real problem with getting washed. They changed to a carer my [family member] will do it for. If it takes them more than the allocated hour, they'll stay and I don't think they get paid extra for this." Information such as the service information pack was provided to people, including in an accessible format, to help people understand the care available to them.

There was an employee of the month board displayed in the office to show that staff were recognised and valued for their contribution for any outstanding achievements they have completed when supporting people with care. One staff member was given the day off for their hard work. The registered manager showed us the compliments and gratitude letters they have received from the people who used the service

and their relatives. One relative had thanked the care worker for their hard work and another person had written, "People are happy to complain but not to let you know when you have done a good job" and described the care workers as 'well mannered'.

Advanced care wishes were written in people's care plans on how people wished to be supported with their end of life needs. Do not attempt restitution (DNAR) was written in files and evidence of discussions with health professionals and their relatives were recorded. The registered manger told us the provider was looking at the possibility of commencing training in the Gold Standard Framework (GSF) so that they may become GSF accredited. The information was also written in the PIR the registered manger had sent to us. The GSF offers training to all staff providing end of life care to ensure better experiences for people.

Good

Is the service responsive?

Our findings

People told us they received person centred care that was responsive to their needs. One person told us, "Someone came to see me while I was still in hospital," and another person commented, "I'm very, very happy with the care I receive." A relative we spoke to described the care as "very good" and explained the reasons why, "When I did have an issue at the beginning I spoke to the manager and she gave them extra training. She gave them different ways of approaching my [family member]. If I have a problem, I know I can phone and they'll sort it out."

Each care plan contained a personal information sheet which had details about the person which included information such as the next of kin contact, their GP or other health and social care professionals, medical conditions and special/cultural needs. Care plans also had other relevant information that was collected at assessment, including emotional well-being, social interaction, level of cognition, nutritional needs and preferences for personal care. There was reference to people's wishes and how they wanted their care needs to be met. One person's records detailed how they would like specific drinks made. Another person's records highlighted how they wanted their personal care to be carried out in relation to their continence needs.

Care plans were person centred and written in the 'voice' of the person who was receiving the care. For example, the care plans told us how old people were and their family relationships such as 'I have a caring and loving relationship with my family' followed by the persons' interests and likes and dislikes. One person liked to 'sit on the balcony' and another explained how the person liked to be 'approached' and made 'comfortable' or the 'type' of cream they liked to be put on certain areas of their skin. Care plans focused on positive outcomes for people and we saw were people had requested a person of the same gender to provide their care that this was met by the service. We spoke with care worker who had a good understanding of the person needs they supported that was living with dementia. People's marital status was written in their plans and where people had no family and relatives carers were advised to ensure people were given the opportunity to make their own choices. This showed us that people's opinions were important and valued and they were involved in discussions about their care. Care plans were clear and comprehensive and had been consistently reviewed.

Communication with people was highlighted in people's care plans as being an important aspect of their well-being. We saw for one person there was a communication plan in place and another person had requested a care worker who spoke Bengali. A relative told us, "It's a proper two-way communication. My [family member] was limping one day and they phoned me to let me know." A person reported the carer always called if they are running late and said, "The actual carer lives a long way away, so sometimes gets stuck on the bus in traffic, but the [care worker] always rings if he/she going to be late. The [care worker] stays for the right time." We saw were a person had been admitted to hospital in the morning that their partner had been informed immediately.

We looked through a sample of daily logs for four people and saw that people were receiving the care and support that they had been assessed for, including the food they preferred. Where there were two care

workers required, both had signed the logs to confirm they had visited the person's home. The daily logs we viewed were eligible and recorded enough information to demonstrate that care had been delivered.

People told us they were able to raise concerns if they needed to and were confident the provider listened and acted on complaints. One person said, "I have had issues with the timing, especially at the weekends I've discussed it with the office and it's been resolved. They have never missed visits."

We saw systems were in place for recording and managing complaints. The provider had received twelve complaints since the previous inspection. The complaints records showed that action was taken within the relevant time scales. The complaints procedure was detailed in the information packs given to people before they used the service. There was a free phone number for people to contact the head office so people's concerns could be recorded and monitored to improve the way the service delivered care. For example, the registered manager told us the service would soon be introducing electronic call monitoring to reduce risk of late calls.

Good

Is the service well-led?

Our findings

People using the service, their relatives and staff gave very positive views about the service and explained the service was easily accessible. One person told us, "I've had to contact the office. I've got the number in my phone. They're always there just if we've got appointments or something," and another person said, "I've had to contact a few times not to make a complaint, just if we've got appointments or something. They're easy to contact."

Staff described the registered manager as "supportive", and "a very good manager", and a care worker reported, "If there are any issues they will try and solve it, especially the [care coordinator] who does the spot checks." One care worker said of the registered manager, "She listen's, if there are any problems she will call you to the office and sort it out."

During the inspection we observed the manager to be highly professional, displayed good leadership skills and was very knowledgeable about the care the service delivered to people in their homes. The registered manager had over 12 years' experience working in health and social care and had completed training that included a higher national vocational qualification (NVQ) in health and social care, risk assessing, first aid, DoLs, MCA, safeguarding and was qualified as an NVQ assessor. An NVQ assessor observes candidates in their workplace to make sure they meet the standards needed to achieve the NVQ.

People confirmed the registered manager carried out quality monitoring calls, visits and satisfaction surveys were sent to people to obtain their feedback about the service. Two people said, "Someone from the office, they come and check. They have been here when the [care worker] is here," and, "The office rings to ask if everything is OK." Another person commented, "I don't think it [the service] could be better." Monitoring forms covered areas such as staff punctuality, dignity and respect, regular care workers and whether visits lasted the full allocated time.

The PIR was sent to the CQC within the required timeframe and was thoroughly completed by the registered manager. Questionnaires had been returned from people who used the service and the results were mainly positive. The CQC manager's registration certificate was displayed on the office wall and the employers liability insurance was up to date.

The registered manager worked in partnership with external stakeholders, such as multi- disciplinary teams, and had attended forums held be the local authority such as the care act forum. Additionally, the local authority carried out monitoring visits and any shortfalls found were acted on and clear improvements made. Incidents that had occurred in the service were used as learning tool to improve the quality of care the service provided. There was a serious incident that the registered manager had previously informed us of and explained how the lessons learned from the incident was used as a training tool for care workers.

The provider kept up to date with relevant areas of good practice through membership of a number of professional organisations, such as the United Kingdom Homecare Association (UKHCA). The UKHCA provide support, guidance and advice for organisations that provide care, including nursing care, to people

in their own homes.

Benchmarking was used by the provider to set new standards of practice such as the National Minimum Data Set for Social Care (NMDS-SC). NMDS-SC is an online system which collects information on the adult social care workforce in England. The systems of record keeping and documentation seen was very well organised and all information asked for was on hand and readily available.

Auditing systems were in place to and improve the quality of care people received. The registered manager operated a range of monthly audits and visits to people's homes. The audits were for care plans, medicines, and recruitment amongst others. However when we viewed a sample of the audits we found some actions were required but not recorded on the specific measures the service had been put in place. We also saw that it was written actions were taken on certain audits but there were no comments to describe the type of action taken.

We recommend that the service seeks advice and guidance from a reputable source, based on current and best practice, in relation to recording quality audits for the service.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment How the regulation was not being met: Care and treatment was not always provided in a safe way for service users as the registered person did not always assess the risks to the health and wellbeing of service users and did not always do all that was reasonably practicable to mitigate any risks and did not ensure the proper and safe management of medicines. Regulation 12 (1) (2) (a) (b) (g)