True Homecare Limited

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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?	**Good**

Summary of findings

Overall summary

This inspection took place on 08 June 2016 and was announced.

True Homecare is a domiciliary care service that was launched in 2012. It is based in Cheadle, Stockport and provides personal care for people in their own homes. At the time of our inspection the service was providing support to approximately 80 people.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We last inspected True Homecare on 24 June 2013 when we found the service to be meeting all standards inspected. The inspection on 24 June 2013 was a follow-up inspection to check the service was meeting requirements in relation to breaches of the regulations identified during an inspection on 08 March 2013. These related to safeguarding, training and supervision and safe recruitment.

At this inspection we identified two breaches of one of the regulations in relation to the safe management of medicines, and in relation to assessing and mitigating risks. You can see what action we have told the provider to take at the back of this report. We have made three recommendations. We recommend that the service develops its' recording systems in relation to monitoring service quality and safety; that it develops a structured approach to the provision of supervision and appraisal to staff; and that it develops its' approach to care planning and assessment.

We found records relating to the support people required with their medicines were not always clear. It was not possible to tell with certainty which medicines staff had prompted people to take as it was unclear if the records of people's medicines were up to date. There was also a lack of clarity or assessment in relation to the support people required with their medicines. This increased the risk people might not be receiving the correct support to manage their medicines safely.

We saw risk assessments were carried out to help identify risks. However, these assessments did not always identify risks that had been documented elsewhere, and they did not always clearly detail what steps should be taken to help reduce any potential risks. For example, we saw risks including self-neglect, falls and weight loss had been identified in local authority assessments. However, the service's care plans and risk assessments did not set out how staff should manage these risks.

There was sufficient numbers of staff to enable all calls to be met. We received three reports of calls having been missed due to factors such as staff not turning up or administrative errors. People told us this was not a common occurrence however, and we saw instances where missed calls had been investigated and actions taken if required.

People told us they were supported by the same staff on a consistent basis. Staff were able to demonstrate that they knew people well, and people reported that they found staff to have a caring and considerate approach.

Staff were able to describe in detail how they had supported people in a sensitive manner and helped to maintain their privacy and dignity. All the people we spoke with told us staff respected their privacy, and relatives told us they did not find staff to be in anyway intrusive.

People told us they felt safe with the staff who provided support to them. Staff were aware of procedures for reporting any concerns they may have in relation to an individual's health or wellbeing, and were able to provide examples of when they had reported such concerns.

Staff received training in a variety of areas including safeguarding, moving and handling, dementia care, first aid and communication. We saw staff had received supervision and their competency had also been assessed through 'spot-checks' carried out by the managers.

We received a number of reports of care staff regularly turning up early or late for visits. Two people we spoke with told us they were unhappy when staff did not turn up on time as this could affect their normal routines. We also received a positive report from a family member who told us they had been impressed by the service when it had worked flexibly to change the support and visit times for their family member at short notice in order to meet their needs.

Safe procedures had been followed in the recruitment of staff. We saw staff had criminal records checks, references and identification in place before they commenced employment. Staff had completed application forms and their suitability for the role also assessed by way of an interview.

People, relatives and staff told us they were always able to get hold of a manager or senior carer, including out of hours. We spoke with several people who told us they had raised complaints, and that they had been dealt with to their satisfaction.

The service used an electronic care management system, and electronic call monitoring that enabled the registered manager to review the services' performance in a variety of areas, including the time and duration of calls, missed visits and provision of supervision. However, there was no formal record of when such checks had been undertaken, or evidence to show any potential trends or issues had been identified.

Staff told us they enjoyed their jobs and felt valued for the work they did. There were regular team meetings, which helped ensure staff received consistent messages in relation to the managers expectations. They also provided an opportunity for staff to discuss people's support needs together.

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.

Records did not allow for it to be determined what medicines people had taken. Lists of people's medicines had not been regularly reviewed and staff had supported people with medicines not recorded on these lists. This meant risks in relation to medicines had not been effectively managed.

Risk assessments had been completed when people started using the service. However, risk assessments did not always consider all risks in relation to an individual's care or how to control such risks.

People told us they felt safe with the staff supporting them. Staff demonstrated a good knowledge of how to identify and report any potential concerns in relation to a person's health or wellbeing.

Is the service effective?

Good

The service was effective.

Staff received a range of training. This included training in dementia care, moving and handling and safeguarding. Some staff had received additional training in specific areas, such as care for people with Parkinson's.

There was a comprehensive induction programme in place. Newly recruited staff told us they were able to shadow other staff members before working alone.

We saw that 'spot checks' had been carried out to assess staff member's competence and provide feedback in relation to areas for improvement. People using the service told us they felt staff were competent to undertake the tasks required of them.

Is the service caring?

Good

The service was caring.

People told us they were supported consistently by the same

staff team. Staff confirmed this and told us they thought this was important in order to build caring and trusting relationships with people.

Staff demonstrated a good understanding of the concerns people may have in relation to their privacy and dignity. They were able to tell us how they ensured people's privacy was upheld as far as possible. All people we spoke with told us they thought staff respected their privacy and dignity.

People and relatives told us staff had a kind and caring approach. People told us staff were patient, supportive and able to communicate effectively with them.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

We received several comments that staff could arrive early or late for calls on a regular basis. The services records indicated around 19% of calls in May 2016 were more than 15 minutes early or late.

People had their needs assessed prior to them starting to receive a service. There was evidence care plans had been reviewed. However, some care plans were limited in the detail they contained.

People told us they would be confident to raise a complaint. People we spoke with who told us they had made a complaint told us they had received a satisfactory response from the service.

Is the service well-led?

Good

The service was well-led.

Staff we spoke with were happy and motivated. They told us they enjoyed their jobs and felt valued by people using the service, the manager and other members of the team.

The service sought the opinion of the people it was supporting. There were systems in place to check the quality and safety of the service, although checks were not always formally recorded.

The registered manager was responsive to feedback provided during the inspection. They sent us an update shortly after the inspection detailing the actions taken and planned to improve the quality of the service.

True Homecare 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.

This inspection took place on 08 June 2016 and was announced. We gave the service 48 hours' notice of our inspection. This was to ensure there would be someone in the office able to facilitate our inspection and to help us plan our inspection effectively.

The inspection team consisted of one adult social care inspector. Prior to the inspection we reviewed information we held about the service. This included statutory notifications the provider is required to submit to CQC about safeguarding, serious injuries and other significant events. We sent questionnaires to 37 people or their relatives to complete prior to the inspection to ask for their views of True Homecare. We received a response from 15 (41%) people overall.

Before the inspection, the provider completed 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 improvements they plan to make. We also contacted the local authority quality assurance team, commissioners and Stockport Healthwatch for any feedback they had on the service. Healthwatch England is the national consumer champion in health and care. We used the information we reviewed to help plan and inform our inspection.

During the inspection we spoke with four staff. This included the registered manager, the senior care co-ordinator, a care assistant and a senior care assistant. We spoke with a further four care assistants by phone on 09 and 10 June 2016. We spoke with two people using the service and two relatives during the inspection, and an additional three relatives and five people using the service by phone shortly after the inspection on 09 and 10 June 2016.

We reviewed records kept by the service in relation to the care people were receiving. This included six care files and four people's medication administration records. We reviewed records related to the running of the

service including, staff training records, rotas, minutes of meetings and three staff personnel files.

Requires Improvement

Is the service safe?

Our findings

Records in relation to the administration or prompting of medicines were not sufficient to allow us to determine that people had received the support with their medicines that they required. We saw staff had completed medication administration records (MARs) to show when they had prompted people to take their medicines. However, we found that records of people's current medicines were not regularly reviewed. For example, one person's record of medicines administered consisted of a photo of the prescribing labels, which was dated February 2015, with no evidence this had been reviewed. Two people's lists of medicines they were taking had no start or finish dates listed and another record showed a start date of July 2014 with no evidence of review. This meant we could not be certain these lists of medicines were current, which meant it would not be possible to determine what medicines people had been prompted to take in instances where staff had recorded 'blister pack prompted'. Blister packs are packages that contain all or most of the medicines that the person requires within one 'blister', which can help people manage their medicines effectively.

We saw two people's MARs indicated medicines in addition to the blister pack had been administered. However, these medicines were not listed on the records of those people's current medicines, and were not detailed in the care plans. The senior care co-ordinator told us one of these medicines may have been a 'when required' (PRN) medicine. However there was no documentation in the care plan to detail when it should be administered. This meant there was a risk staff may not be supporting these people with their medicines correctly. It was also contrary to the service's medicines policy, which stated staff could only support people with medicines listed on the medicines sheet. We found there was a lack of clarity in one person's care plan as to whether staff or the person themselves were responsible for their medicines. We discussed this with the registered manager who demonstrated an awareness of the agreement with the individual and their family in relation to management of their medicines. This information was not clearly reflected in the care plan. We also found there had been no recorded assessments carried out in relation to the support people required with their medicines, which was also contrary to the service's medicines policy.

One person's care plan indicated their drinks should be thickened. There was no information in this person's care file to indicate how thick drinks should be made. The registered manager told us there was further guidance kept for staff at this person's home, though we were unable to verify this. They also said staff would follow the instructions on the prescribing label for the thickener. We checked this person's MARs and found there was no record of the use of the thickener, and the thickener was not listed on this person's medicines list. This meant it could not be evidenced that the thickener was being used in a safe way and in accordance with directions from a medical professional.

These issues in relation to the safe management of medicines were a breach of Regulation 12(1) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People we spoke with told us they felt safe with the carers who provided them with support. One person told us; "I do feel safe, absolutely. They remember to lock the door when they leave. They are very caring and careful." Staff we spoke with were aware of how to identify potential signs of abuse or neglect and of

procedures in relation to reporting any such concerns. The registered manager and staff we spoke with were able to discuss examples of instances when they had identified safeguarding concerns and made the appropriate referrals to the local authority safeguarding team and police where required. One staff member told us they provided support to the same people on a regular basis. They said they thought this was important in helping ensure they were able to notice any changes to a person's presentation that might indicate something was 'wrong' and that they would need to draw to the attention of a manager.

We saw risk assessments were completed as part of the initial assessments when people started to use the service. There was consideration of a range of potential risks, including any potential risks in relation to the environment, moving and handling, behaviours that challenge and facilities for the disposal of waste products. There was evidence in some cases that where potential risks had been identified, actions were identified to reduce risks. For example, the risk assessment for one recent referral identified an action for the care co-ordinator to contact the fire service to ask for smoke detectors to be fitted. We saw where there were additional risks in relation to moving and handling, that risk assessments had been carried out to help guide staff how to support people safely and to minimise potential risks to staff and the individual. However, we found examples in three people's care files where potential risks identified in local authority assessments or the service's own initial risk assessment did not have clear plans documented to inform staff how they should appropriately manage these risks. This included risks in relation to falls, self-neglect, behaviours that challenge and weight loss. For example, one person's local authority risk assessment identified a history of behaviours that challenge. However, the service's initial risk assessment indicated there were no concerns in relation to behaviour. Another person had recently started using the service and the initial assessment indicated there was a requirement to 'keep an eye on' this person's' weight. It had not been considered during the initial assessment how this should be done, or what staff should do if they noted any weight loss. This meant there was a possibility that potential risks were not being adequately mitigated.

This was a breach of Regulation 12 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The service had increased the number of people it was providing support to by approximately 30 people between February and June 2016. The registered manager told us there was an on-going process of recruitment to help ensure there were sufficient numbers of staff to meet all calls. We calculated the number of available staff hours against the number of hours support being provided at the time of the inspection. This indicated there were sufficient numbers of staff available to allow calls to be met, including contingency hours to allow flexibility if a member of staff called in sick for example. Staff told us they thought there were sufficient numbers of staff to be able to meet all scheduled calls and told us the care co-ordinators would provide support if staff cover could not be found due to staff calling in sick at late notice.

Three people we spoke with told us there had been instances where care staff had not turned up for a scheduled call, though all said this was not a frequent occurrence. We saw there was a record of any missed visits kept on the service's electronic care management system. Where visits had been missed there was evidence that the reasons for this had been investigated and actions taken when required, including disciplinary action against staff. The registered manager told us the call monitoring software should alert them to any missed calls in most cases.

The registered manager told us there was a team of three staff who worked an on-call rota. Staff we spoke with confirmed they never had any difficulties contacting a manager for support or advice should there be a need. One staff member told us; "I'm always able to get through to the on-call. I've worked nights before and you're always able to contact a manager." We saw the service had a policy in place in relation to actions to take if staff were unable to gain access to someone's house at the time of a scheduled call. Minutes from a

recent staff meeting showed this had been discussed with staff to ensure they were clear about the procedure. This would help ensure staff took appropriate actions to ensure the wellbeing of people they were supporting.

We reviewed staff personnel files and saw evidence that procedures had been followed to help ensure staff recruited were of good character and suitable to work with vulnerable people. Staff had completed application forms, which documented a full employment history. There were documented records of staff interviews, and appropriate references had been sought from previous employers. The service used an online system to apply for and track the progress of disclosure and barring service (DBS) checks. The records we checked showed that DBS checks had been received prior to the staff member commencing work. A DBS check provides details of any police record and whether the individual has been barred from working with vulnerable people. This helps employers make safer decisions when recruiting staff.

Good

Is the service effective?

Our findings

We asked people and their relatives whether they thought the care staff that supported them were competent and able to meet their needs. Everyone told us they thought staff had the skills and training required; although one person and two relatives told us that they found competence could vary widely between different staff members. Comments made by relatives and people using the service included; "They are quite good in comparison [to other care services];" "They are good. Well trained and well presented;" "You can tell the staff who have worked in nursing homes, who are superior;" and "Some know what they're doing, others need to learn. I think most staff are competent but some are better than others."

People told us staff completed all the core tasks required during their visits. Relatives and people told us some staff would help with extra tasks such as washing-up or putting the bins out if they had time during their call. They said staff willingness to help with these tasks could vary between different staff members.

We checked records of staff training and saw training had been provided in a range of areas. This included: safeguarding, infection control, the Mental Capacity Act, dementia, effective communication, equality and diversity, health and safety, first aid and moving and handling (practical and theory). Some staff had undertaken additional training in areas such as providing care to people with Parkinson's or people who had had a stroke. This would help ensure staff were competent to meet people's individual health and social care needs. Staff told us they felt they received sufficient training and support to enable them to undertake their role effectively. One staff member told us; "If we feel we need a bit of training [the senior care co-ordinator] will put it in place. I'm doing booklet training at present and we have been told we can do as many as want to." Booklet training involved staff completing workbooks in areas such as dementia care and discussing their progress with an assessor. The registered manager told us they had recently introduced a level 2 training course in dementia care. Staff we spoke with confirmed they were undertaking this training. They were able to explain aspects of their learning to us; such as how dementia could affect the people they were supporting.

We saw there was a comprehensive induction programme in place, which involved staff being given information about policies and procedures as well as undertaking induction training in topics such as medicines, moving and handling and safeguarding. The registered manager told us new staff would shadow more experienced staff for a period of at least two days and would have their competency checked. This was confirmed by staff we spoke with who had been recently recruited. We saw induction checklists had been completed and signed off by the staff member and their supervisor, which indicated staff had completed their inductions. We also saw evidence of competency assessments or 'spot checks' in staff files. These checks involved a supervisor observing the staff member's practise during a call to a person who used the service. The documents indicated feedback was given that would help staff develop and improve their practise. For example, we saw in one spot-check it was recorded that the supervisor had discussed correct procedures in relation to infection control as they had not removed their gloves following the provision of personal care before starting other tasks.

Staff told us they received supervision, although we did not receive a consistent answer as to how frequently

they were held. We looked at the supervision matrix, which indicated all staff had received supervision in the past year and approximately half of the staff had received supervision in the past six months. The registered manager told us there was no supervision policy that indicated how frequently staff should receive supervision, and they acknowledged supervisions were not always recorded. Records of supervisions held demonstrated that discussions had taken place with staff in relation to objectives, training and their performance. Staff told us they were in frequent contact with managers and felt well supported.

We recommend the provider clearly documents the arrangements and expectations in relation to providing staff with supervision, appraisal and support.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA.

The registered manager told us no-one they were providing care and support to was subject to restrictive practices that would amount to a deprivation of liberty. We discussed the requirements of the MCA with the registered manager who was able to demonstrate an awareness of the process to be followed should they need to make an application to the supervisory body for authorisation to deprive a person of their liberty if required. The registered manager was also able to explain the circumstances when best interest decisions may need to be taken in relation to the care people were receiving, and they gave us examples of when best interests processes had been followed.

Staff we spoke with were able to demonstrate an understanding of the principles of the MCA, such as the requirement for decisions to be made in people's best interests, and the understanding that people with capacity had the right to make their own decisions. We asked staff how they would seek consent to provide care and support to people, including people who may have limited verbal communication. Staff told us they would always explain what they were going to do and ask people if they were happy with that. They said they would look for non-verbal signs such as behaviours if a person was unable to give their consent verbally. People we spoke with all confirmed staff asked their permission before providing any care or assistance.

Two of the people we spoke with were supported with the preparation of meals. One person told us staff made their breakfast and supper. They said staff always asked what they wanted and were able to prepare these meals to their satisfaction. We saw initial assessments carried out identified if people had any allergies or specific dietary requirements.

We saw from records kept on the electronic care management system that the service contacted health and social care professionals such as GPs and social workers if they felt any advice or input was required. The senior care coordinator told us no-one's weights were being monitored at the time of our inspection, but that this would be done if they were asked by a health or social care professional. The senior care coordinator told us food and fluid intake would be monitored through the daily records of care if people were receiving such support.

Good

Is the service caring?

Our findings

Everyone we spoke with spoke positively about the kind and caring approach of the care staff who visited them. Comments included; "Staff are caring and friendly"; "Staff who have been out have without exception been lovely and have done what was expected"; and "The attitude of care staff is important… [Staff member] and [Staff member] are excellent in attitude, ability and their work ethic."

People told us they were supported by the same group of staff on a consistent basis, other than on occasions where cover was required at late notice. One relative told us; "Mum knows the girls. It tends to be the same ones, a core of four to six staff." Staff talked about the importance of working with the same people in developing positive and caring relationships, and told us they were enabled to do this. Staff were able to speak with us in depth about people's care and support needs, and demonstrated that they knew the people they supported very well.

Staff spoke with us about having provided care at the end of people's lives. One of the carers told us they had undertaken training in end of life care with the hospice. They spoke about the importance of supporting families as well as the people using the service, and provided examples of times when they had developed strong supportive relationships with all people involved in an individual's care. One relative we spoke with told us how they had found the main member of care staff to be very supportive and reassuring for them, as well as their family member.

Everyone we spoke with told us staff were able to communicate effectively and clearly with them. One relative told us; "They are really patient and there is good communication and interaction with [family member] as well." Staff were able to explain to us how they would communicate effectively with people who had limited verbal communication. They told us that working with the same people on a consistent basis facilitated effective communication and gave us examples of non-verbal communications people they had supported used, and what they meant.

We asked staff what steps they would take to help ensure people's privacy and dignity was respected as far as possible. They told us they would close the curtains when providing personal care and keep people covered as much as possible when supporting with personal care. One carer told us people could be embarrassed when receiving support with personal care for the first time. They provided a good account of how they had provided effective, sensitive support that helped uphold a person's privacy and dignity when providing personal care to them, as this person had expressed particular concerns in relation to this aspect of support. People we spoke with all told us they thought staff were respectful of their privacy. They told us staff would always knock before entering their house and would announce their arrival. One relative told us they had been concerned about staff coming into the house as they had not been used to such arrangements before. However, they told us they had found staff to be respectful and had not found any staff to be 'intrusive'.

People told us they felt staff supported them to be as independent as they could be. One person talked about requiring less support than they used to, so the care staff were not required to provide the same level

of assistance as they previously did. One relative spoke positively about the support they received allowing their family member to remain at home. Staff told us they would encourage people to do what they could for themselves, providing support as required.

People using the service and their relatives told us they were always able to speak to someone at the office, including out of hours if they had any issues about the service they needed to discuss. We saw people were provided with a copy of a 'service user' guide that contained important information about the service and what people could expect from it.

Requires Improvement

Is the service responsive?

Our findings

We saw people had their needs assessed prior to starting the service. People and relatives we spoke with confirmed they had been visited by a member of staff from True Home Care who had talked to them about their care needs and preferences.

Care plans had been completed to varying degrees of detail, and with variable amounts of information in relation to people's preferences and needs. The care plans were written to detail people's usual routines and basic support requirements. Some care plans contained information on people's preferences, such as how staff should arrange their bed, or what they liked to eat and drink at meal times. Other care plans contained less detail and were limited in their scope. For example, we saw care plans that contained simple statements such as 'assist [person] with showering' without additional detail on how staff should assist that person to ensure it met their needs and was in accordance with their preferences. The senior care co-ordinator told us they would review the notes carers had made when supporting people and would use these to develop more in-depth care plans as they got to know people. We saw some people's families had contributed to the care planning process by completing documents to provide information on people's social histories, likes, dislikes and interests. This would help staff get to know people and enable them to build positive relationships.

Care plans we reviewed did not show any evidence of having been reviewed on the actual document. However, the registered manager showed us updates in relation to people's care that were recorded on the electronic care management system. Following the inspection the registered manger provided evidence of 'care plan checklists', which were a simple prompt for staff to inform them of the support people required, as well as a 'care plan review' form. The registered manager told us these documents were kept in people's homes to ensure staff were aware of current care needs. They told us these updates corresponded to updates recorded on the care management system. The review forms evidenced that reviews of care plans had taken place on a six monthly basis or when a change was required. The registered manager informed us they had identified that improvements with care planning could be made. They had booked senior staff onto training to help build staff skills in this area, and to support improvements.

We recommend that care plans and initial assessments are developed to ensure they provide a thorough assessment of needs and preferences in relation to all care a support required by people using the service.

Staff told us assessments and care plans were always in place before they were required to provide support to anyone. They told us they usually had opportunity to read people's care plans before supporting them, except on occasions when they were required to support someone at late notice due to another member of staff not being able to attend for work that day. They told us that in these circumstances they would call the office and get a handover of the person's needs from one of the care coordinators.

We asked staff to provide us with examples of how they worked flexibly to meet people's needs and preferences. One staff member told us it was important to build trust and confidence with people, and to adapt their care to meet their needs. Other staff talked about people's preferences in relation to foods or

routines. One relative we spoke with told us they had been impressed by True Home Care being able to work flexibly by changing visit times at late notice to provide support to their family member following a change in their needs. The registered manager told us they employed two male care staff at the time of our visit and would check whether people were happy to be supported by a male member of staff before putting them on the rota for someone's call. People we spoke with told us they had no issues in relation to the gender of their support staff. One relative told us their family member had benefitted from receiving support from a male member of staff.

We received a varied response when we asked people whether care staff arrived on time for their calls. Two people told us they had not had any issues in relation to the timing of their calls. However three people using the service and two relatives we spoke with told us care staff arrived early or late on a regular basis. One person told us; "They often run late. It's no good as I can be waiting to get dressed." Two people told us they thought delays were caused due to staff needing extra travel time or getting delayed when supporting the previous call. We asked staff whether they felt they received sufficient travel time. Two staff told us they thought they did received sufficient travel time, while two told us there were times when they could be busier and travelling time was not sufficient. The registered manager provided us with a report from the electronic call monitoring system. This showed that 19% of the visits carried out in May 2016 were early or late by more than 15 minutes.

The service had a complaints policy, including a simple complaints procedure that was documented in the service user guide. The registered manager told us there were no current complaints. They showed us records of previous complaints, though these weren't easy to locate due to the way they were recorded on the electronic system. The registered manager told us they would request the categorisation system to be updated so that it would clearly highlight any complaints received. People told us they would feel confident to raise a complaint by contacting the office if required. We spoke with people who told us they had raised complaints in the past. They told us they had been satisfied with the response they received and with the actions taken by the service.

Good

Is the service well-led?

Our findings

The service had a registered manager in post as was a requirement of their conditions of registration. The registered manager was supported by a senior care coordinator who in turn managed a team of care coordinators and care staff. The service had also recently introduced the role of 'senior carer'. The registered manager told us staff were being selected for these roles based on their experience, professionalism and quality of care provision. The intention was for this role to act as a link between people using the service and the care coordinators/managers, for example through conducting 'quality reviews' of people's service with them.

We looked at the systems and process in place to monitor and improve the quality and safety of the service. The registered manager told us 'quality reviews' were undertaken with people using the service. We saw copies of these reviews, which showed people using the service were asked questions such as whether their support was timely, whether staff were polite and courteous and whether they had a copy of the form available to record any formal complaints on. There was a simple analysis of the findings of these surveys, which would help the registered manager maintain an awareness of any trends or potential issues arising. The electronic care management system indicated approximately one third of the people receiving support from the service had had a quality review in the past six months. One person we spoke with told us they had taken part in a recent quality review, and another person who had recently started using the service told us they had received a call-back from the service after a couple of weeks to check everything was satisfactory.

The service used an electronic care management system that worked alongside the electronic call monitoring system. The registered manager demonstrated a good knowledge of how to use these systems to access information and produce reports. For example, they were able to generate reports in relation to the timeliness and duration of calls, accidents/incidents, missed visits, supervisions, training and records of updates and changes to care plans. The registered manager told us they regularly went through such reports with the senior care coordinator. However, there was no record of this or analysis produced that would help identify any trends or areas for improvement.

The registered manager told us records such as MARs and daily notes were returned to the office on a monthly basis, unless there was a reason this couldn't be done, such as if a person was in hospital. The registered manager told us they would check these records when returned and take actions to address any concerns identified. We saw a record of this check, which consisted of a simple check-box by each individual's name. These checks didn't indicate if any discrepancies or issues had been identified in relation to these records, or what actions, if any had been taken. The registered manager told us any issues and actions taken would be noted on the electronic care management system. They showed us evidence of instances when this had been done.

We recommend that the service develops a clear framework for audit and quality assurance, and that any such audits are clearly recorded.

All staff we spoke with told us they were happy in their jobs and felt supported and valued by the company

and management. One staff member said; "The office is always open. We're told we can always come to the office. You can tell you're valued by the way management talk to you. I've never had a disagreement or been told just to get on with it." Another staff member told us; "I love my job. I feel valued and appreciated." The registered manager told us; "If staff feel happy and feel valued they will go the extra mile." They told us that whilst staff were employed on zero hours contracts, they would ask staff at interview how many hours they wanted to work and would always try and provide this. They also told us they held social events for staff such as parties for Eid and Christmas.

Staff told us they had opportunity to attend staff team meetings. Minutes from these meetings indicated they were held on a monthly basis. We saw discussions had been held in relation to individual's care and support needs, as well as topics such as confidentiality, staff conduct, and use of mobile phones. This helped to ensure staff were aware of their responsibilities and the manager's expectations.

Following our initial feedback from the inspection, the registered manager sent us an update detailing improvements they had made or planned to make. For example, they told us they had implemented a new medicines risk assessment that would be in place for all people who used the service by August 2016. This showed the registered manager was responsive to feedback and used it to make improvements to the service provided.

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 The provider was not adequately assessing potential risks to people using the service. Medicines were not being managed safely. Regulation 12 (2)