Sevacare (UK) Limited

Mayfair Homecare - Westminster

Inspection report

Suite 20, Redan House
23-27 Redan Place
London
W2 4SA

Date of inspection visit:
28 February 2018
01 March 2018
07 March 2018

Date of publication:
29 March 2018

Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 carried out this comprehensive inspection of Mayfair Homecare-Westminster on 28 February, 1 and 7 March 2018. At our previous comprehensive inspection in January 2017 we found a breach of regulations regarding safe care and treatment and rated the service 'Requires improvement'. We undertook a focussed inspection in July 2017 where we found the provider had successfully addressed this breach, but found a further breach regarding the management of medicines.

At this inspection we found that the service was now meeting regulations and we have changed their rating to 'Good'.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides care and rehabilitation services to older adults and support to people with mental health needs in the London Borough of Camden and the City of Westminster. At the time of our inspection the service was providing personal care to 83 people. Not everyone using Mayfair Homecare-Westminster receives 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 take into account any wider social care provided.

The service had a registered manager, who had been in post since November 2017 and completed their registration in February 2018. 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.

People told us they were treated with kindness and respect by staff. People's views were sought through reviews and telephone monitoring. Accurate assessments of people's needs were carried out yearly and care plans were designed to meet these needs. Care plans were concise and contained accurate and important details about the care people required and wanted. Care workers demonstrated they had delivered care as planned through accurate recording. People had consented to their care in line with the Mental Capacity Act 2005 (MCA).

Suitable recruitment systems were operated by managers to make sure that staff were suitable for their roles. There were good systems in place to make sure care workers arrived on time and that people were protected from the risk of missed or late calls. Care workers received the correct training and supervision to carry out their roles. Managers undertook spot checks and care worker assessments to make sure that care and support were delivered effectively and in a caring manner. This included carrying out additional checks where there were concerns about staff performance.

We had previous concerns about how medicines were managed, but at this inspection we found people's support with medicines was correctly planned and managed by care workers. Regular checks were carried

out by managers to make sure that this was carried out safely. We identified two areas where the provider could further improve medicines management in line with best practice guidance and have made a recommendation about this.

Care plans detailed the support people needed to eat and drink and people's dietary preferences. There was evidence people received varied diets. People knew how to complain and when this happened complaints were appropriately investigated and responded to, although the provider did not always record whether people were satisfied with the outcome.

Managers had carried out a comprehensive audit of the service, including of people's care files and the recruitment and oversight of staff. Care workers told us they felt well supported by managers. There were systems in place to monitor staff training, background checks of care workers and people's reviews. Where audits identified issues these had been correctly addressed. This had resulted in clear improvements in the management and operation of the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were suitable measures to safeguard people from abuse.

Staff were usually punctual and the provider had systems to protect people from missed or late calls. The provider operated safe recruitment processes to make sure that staff were suitable for their roles.

Medicines were safely managed and there were checks in place to make sure people received their medicines.

Is the service effective?

Good

The service was effective.

Detailed assessments were carried out of people's care needs and these were reviewed yearly.

The provider ensured staff had the right training to do their jobs and there were systems of supervision and spot checks to check staff were delivering care effectively. People had the right support to eat and drink. Concerns about people's health were noted and appropriate actions taken.

People had consented to their care in line with the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

People told us they were treated with kindness and respect. Care plans demonstrated how to protect people's dignity and managers checked this was taking place.

The service carried out monitoring and reviews to obtain people's views about their care.

Is the service responsive?

Good

The service was responsive.

People's care was planned around the needs of the person, delivered in line with these and reviewed regularly to see if anything had changed.

People knew how to complain and complaints were appropriately investigated and responded to.

Is the service well-led?

Good

The service was well-led.

Managers used team meetings and communications to make sure care workers understood what was required. Care workers told us they felt well supported by the office staff.

Managers had audit systems in place to make sure that records were maintained accurately and made sure that issues raised by audit were addressed correctly. Care workers kept accurate and complete records of the care they had delivered.

The service notified the Care Quality Commission (CQC) of serious incidents as required.

Mayfair Homecare - Westminster

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.

Why we inspected. This was a routine inspection which we carried out as the provider had been rated 'Requires Improvement' 12 months ago. Since our previous focussed inspection in July 2017 we were aware of four allegations of possible abuse, including neglect. One of these concerned an incident where a care worker missed a number of calls due to a miscommunication about their working days. Two of these concerned emotional abuse by care workers which were investigated but not substantiated. One concerned an allegation of financial abuse, which was also not substantiated. We were also aware of an allegation regarding the management of a person's medicines and poor continuity of staff. We found that this was not pursued as a safeguarding matter but the provider had investigated and addressed this.

Prior to carrying out the inspection we reviewed information we held about the service, including significant events the provider is required to tell us about. The provider completed a provider information return (PIR). This is a document where providers give information about their service, including what is going well and their plans to improve the service in future. We also contacted contracts and monitoring officers from the local authority to get their opinion on the quality of the service.

This inspection was carried out on 28 February, 1 and 7 March 2018 and was announced. We postponed the third day of the inspection from 2 March due to severe weather conditions. We gave the service 48 hour's notice of the inspection visit because staff were often out of the office or providing care. We needed to be sure that they were in.

The inspection visit was carried out by an adult social care inspector who was accompanied on the final day

by a pharmacy inspector. On the 28 February an expert by experience made calls to people using the service, and contacted seven people using the service, two relatives and a health and social care professional working with a person using 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. We spoke with the area manager, registered manager, care services director, team leader, co-ordinator, administrator and four care workers. We also spoke with a social worker involved in the care planning of a person using the service.

We reviewed records of care and support and electronic call monitoring relating to eight people using the service and records of medicines management for 11 people. We looked at records of recruitment and supervision for five care workers and records of training for all staff. We reviewed records relating to safeguarding, complaints and incidents and records relating to the management of the service, such as audits, satisfaction surveys and the rotas for 10 care workers.

Good

Is the service safe?

Our findings

At our previous inspection in July 2017 we found a breach of regulations regarding the management of medicines. This was because there were often inconsistencies between how medicines administration recording (MAR) charts were completed by care workers and in some cases there were gaps in these records which were not suitably addressed by audits. Some MAR charts did not contain clear administration instructions for care workers to follow and sometimes care plans and risk assessments did not accurately reflect the support people received.

At this inspection we found the provider was now meeting this regulation.

People who used the service gave examples of how care workers managed their medicines well. Comments included, "They open the containers and give me water to take them and they write it down" and "[My carer] sticks to the rules, she can't even buy me paracetamol".

We checked medicines risk assessments, MAR charts and medicines audits. We saw through audits that prescribed medicines were available at people's homes and this assured us that medicines were available at the point of need and that the provider had made suitable arrangements about the provision of medicines for people.

We looked at 11 care plans for medicines and found that people's medicines preferences and risks were documented so that staff knew how to safely give medicines in a way that suited the person. We found that there were clear instructions on what help people needed with their medicines, for example, help with application of patches or creams. We found that people's allergies were documented in their medicines risk assessments but not on the MAR chart. We found that the self-administration of medicines was risk assessed initially by the service and documented in the care plan. This included individual items such as inhalers, creams and patches. Staff we spoke with told us they would speak with people's GPs or pharmacists in case they had any concerns or needed any advice.

The medicines risk assessment outlined who was responsible for ordering and receiving medicines for people. Medicines received by the provider were checked by the care worker for accuracy before administration and any discrepancies were followed up with the GP or pharmacy. If medicines were out of stock, staff told us they proactively investigated alternatives with the GP or pharmacy. Unwanted medicines were returned to the nearest community pharmacy for appropriate disposal in line with good practice.

People received their medicines as prescribed. We looked at 11 MAR charts and found minimal gaps in the recording of medicines administered, which provided an overall level of assurance that people were receiving their medicines safely, consistently and as prescribed. Where there had been gaps on MAR charts these had been noted in audits and the correct action had been documented. We found that in these cases care workers had noted in the communication log that they had given these medicines, therefore we were assured there were no safety concerns in these instances. We found that there were separate charts for people who had topical medicines prescribed to them, such as for dry skin. These were filled out

appropriately by staff. There was a process to update MARs when medicines were started, changed or stopped and the care workers were responsible for this. However we did not see evidence of this checked by a second trained staff member which could further reduce the risk of errors.

On MARs we saw that people were able to obtain their 'when required' (PRN) medicines at a time that was suitable for them. Staff were trained about when to offer these medicines including looking for non-verbal cues and symptoms that might be demonstrated. This was documented in the medicines risk assessments that we saw. Staff we spoke with were able to demonstrate the reasons for giving these medicines, how many to give, what to expect and what to do in the event the medicine did not have its intended benefit.

Medicines were administered and recorded by staff who had been trained in medicines administration. We also saw evidence of annual competency checks so that staff had an annual review of their knowledge, skills and competencies relating to managing and administering medicines. We talked to a member of staff about giving medicines to a person and were assured that staff had a caring attitude towards the administration of medicines for people. For example, if a person refused their medicines initially, staff would try to administer their medicines a short time afterwards. For medicines that were time specific such as alendronic acid, staff were able to demonstrate the correct times these should be given and sought to prioritise these medicines when administering them to people.

Staff checked what medicines people took when they arrived at the service and recorded it on the personalised medicines risk assessment. They sought this information from the person directly, but referred to their community pharmacy or GP if required for clarification. There was a process in place for sharing information about a person's medicines when they moved from one care setting to another. For example a copy of the MAR chart was sent with the person if they were admitted to hospital along with their medicines.

We found that the provider had a medicines policy which reflected current guidance and was up to date. We saw evidence of MAR chart audits that were done monthly or more frequently, for example when there was a new person to the service or new care worker administering medicines. Staff checked that people received their medicines at three different time points; every four weeks when there was a new MAR cycle, when people changed their medicines and during spot checks by the manager, which were documented in care worker files. If medicines gaps on the MARs were identified, these we followed up with the care worker to ensure people had received their medicines. Medicines errors were discussed in monthly meetings and learning shared amongst the rest of the team, and we saw evidence of this documented.

The recording of allergies on MAR charts and the checking of changes to MAR charts by a second member of staff are good practice recommendations in 'Managing Medicines for people receiving social care in the community' by the National Institute for Health and Care Excellence (NICE). We recommend the provider review procedures for the management of medicines in line with this guidance.

People told us they felt safe when their care workers visited. Comments included, "They mean well", "I've had them for more than 9 years so I do feel safe" and "They're careful and I trust them".

The provider had suitable safeguarding measures in place. Care workers received training in their induction about safeguarding adults and this was reviewed every three years. Staff we spoke with were knowledgeable about forms of abuse and their responsibilities to report this. Care workers were confident that managers would take their concerns seriously and act accordingly. Comments included, "I always tell my manager if we feel a concern or if the person is not well or if we're not doing a proper job, we have to report, it's our duty "and "I informed my line manager and things were taken up and were resolved." There was a safeguarding policy which outlined the different types of abuse and was clear about staff responsibilities when abuse was

suspected, this included a clear list of 'dos and don'ts' when abuse is disclosed. We saw examples of allegations being investigated with care workers and follow up actions taken as a result. Allegations were appropriately reported to the local authority who were kept updated about the provider's response.

Risk assessments were comprehensive in their scope and contained appropriate and detailed risk management plans for people. The general risk assessment covered the person's living environment, fire safety, any infection hazards and issues relating to the person's mental health. Risk management plans covered a wide array of factors based on the person's needs, such as those relating to cross-infection, providing safe personal care, risks from the person's health conditions such as diabetes or dementia and providing appropriate nutrition and hydration. Where risks to people's skin integrity were highlighted, there were appropriate management plans in place such as repositioning people, applying creams and completing regular skin integrity checks.

These plans were reviewed on a yearly basis and there was evidence that the provider was taking action when they were concerned that care might not be safe. For example, two people's risk assessments had been reviewed in response to concerns from staff that the person could no longer be safely supported by one staff member. We saw the provider had worked with the local authority and people and their relatives to provide double-handed calls to address this risk. Moving and handling risk assessments were clear about the level of support required, and identified factors such as height and weight, mobility difficulties and constraints on moving the person. It also included any factors relating to the person's comprehension, behaviour and their environment, which could affect safe moving and handling. This included obtaining details of any equipment which was in place to support moving and handling, and checking that servicing was in date.

Where people's assessments showed a risk of falls, the provider carried out a falls risk assessment. This included checking areas which may lead to a high risk, such as a recent history of falls, having four or more medicines or conditions such as stroke or Parkinson's disease. Staff also carried out a practical exercise to see whether a person was able to stand from a chair without using their arms, and used this to assess the overall level of risk.

The provider operated safer recruitment processes to ensure care workers were suitable for their roles. This included obtaining a complete work history and evidence of satisfactory conduct in previous employment by taking up references. References were verified by telephoning referees to make sure that they were genuine. Prior to starting work the provider also obtained evidence of people's identity and address and carried out a check with the Disclosure and Barring Service (DBS). The DBS provides information on people's background, including convictions, to help employers make safer recruitment decisions. There was a risk assessment process in place should there be information of concern on a DBS check, however this was not required for any of the files we checked. The provider also maintained an overview of when people's last DBS checks were carried out in order to make sure these were updated in line with their contractual requirements.

The provider used electronic call monitoring (ECM) systems to ensure that care workers arrived on time to calls. This required staff to use a mobile phone to scan a code which was kept in the person's house. Following an incident where a care worker did not arrive at work due to an apparent miscommunication, the provider had reviewed their procedures and provided training to office staff to check the system on an hourly basis to ensure that care workers had arrived. During our visit we saw examples of co-ordinators contacting care workers as they had not logged in in order to check they had arrived. This protected people from the risk of missed visits. The provider had a dedicated on call service which checked this system out of hours. We did not see any evidence of further missed calls having taken place. Rostering systems also clearly

highlighted when a call was not allocated to a particular worker, for example due to a care worker being off sick, or when people's calls were temporarily suspended. This meant that calls were then reallocated automatically when people returned home or when care workers returned to work, which reduced the chance of calls not being booked. The registered manager told us, "It's a fantastic tool".

People told us their care workers generally arrived on time. Comments included, "If she's 10 or 15 minutes late they phone me" and "They let me know if they're running late." We found care workers usually arrived on time for their calls. The local authority had an agreement that care workers could arrive within 15 minutes of the planned time. We looked at a sample of punctuality data from care logs and compared this with what care workers had logged using ECM. We found a good agreement between this information. We looked at a sample of eight people's calls for a week in January 2018, which covered 143 visits, and found that 81% of calls were within 15 minutes of the planned time and 93% of calls were within 30 minutes of the planned time. Where people's calls were delayed, for example due to care workers being detained with previous calls, people were informed of this and the reason for the delay.

There were no systematic reasons for calls being late. Care workers we spoke with told us that they had enough time to travel to their calls. We reviewed 10 staff rotas, which covered a sample of 245 calls and assessed travel time against a journey planning tool. We found that 92% of calls had enough time to arrive within 15 minutes of the planned time and 98% had enough time to arrive within 30 minutes.

People told us that staff used appropriate measures to maintain infection control. Care plans contained information on infection control measures, such as the use of personal protective equipment (PPE), and we saw care workers coming into the office to collect this equipment. Care workers received training on infection control as part of their induction and received refresher training in this area every three years. As part of the recruitment process, the provider carried out a health questionnaire, which included checking whether care workers had been in contact with infectious diseases such as MRSA and tuberculosis.

Good

Is the service effective?

Our findings

The provider carried out detailed assessments of people's care needs, and these were reviewed yearly. Assessments were comprehensive in their scope, and included looking at people's living arrangements, access to their property, physical and mental health needs, communication needs and movement and mobility. The provider assessed people's needs in areas such as diet and nutrition, continence, skin integrity, social interactions and financial support, and recorded people's expectations and preferences for their care.

Staff received suitable training and supervision to carry out their roles. As part of the recruitment process, staff were required to carry out a verbal reasoning assessment which involved reading a care plan and then answering questions to demonstrate their comprehension. On induction, care workers received training in a wide range of mandatory areas. These included personal care, people handling, record keeping, reviewing policies and procedures, person centred care, health and safety, fire awareness and dealing with emergencies. Some courses were designed to support staff to meet people's health needs, including dementia care, diabetes awareness and pressure sore care. The provider's head office recorded when care workers had received mandatory training on a rostering system and the registered manager checked this weekly and submitted a report containing training which would soon expire. Where a recent report had highlighted some care worker's moving and handling training was about to expire, we verified that this had been carried out promptly. The rostering system did not allow care workers to be allocated calls if mandatory training had expired. This meant that training was kept up to date.

Care workers also received suitable supervision from their line managers. Supervisions were carried out every four months and included discussing matters arising from the last supervision and recent changes since then, with a clear action plan agreed at the end. Managers used the opportunity to discuss whether people were happy in their roles, their expectations around communication and whether any additional training was required. Annual appraisals were carried out, where care workers were asked to reflect on what had gone well for them and where they needed to develop. They could also rate their performance in key areas such as job knowledge, dependability, team work and communication.

Team leaders also carried out care worker assessments in people's homes, where they checked that staff had adhered to key requirements such as safe moving and handling, personal hygiene, medicines, friendliness and communication. This included checking whether staff used appropriate techniques to provide personal care and make sure people's body temperature was maintained, and gave feedback on their observations at the end. Managers had systems in place to check care workers had up to date supervision and assessments and received these regularly. In addition to this, we looked at the files of care workers where there had been concerns about their performance or conduct. We found in these cases managers carried out additional supervisions in order to discuss concerns and outline the standards expected of care workers. This was followed up with additional spot checks and care workers assessments to check that people's performance had improved.

Care plans contained information about the support people needed to eat and drink. At the time of our

inspection nobody using the service required a special diet or support with eating. Care workers recorded the support they gave people, for example preparing and serving meals and maintained a record of what people had eaten, which included providing drinks and supporting people to eat fruit and vegetables. Plans included information on what people wanted for breakfast, when this was part of their care plan, and useful information on risks relating to food and drink. For example, one person's plan highlighted to make sure their drinks were not too hot as the person had a tremor.

Where working with other organisations, plans were clear about who was responsible for which area of care, for example when district nurses provided support with wound management, but plans sometimes lacked detail on exactly what support other parties provided. When carer workers not employed by the agency worked alongside the provider's care workers, there was clear information on what their role was and care workers recorded this appropriately.

Care plans were clear about the support people needed to stay healthy and well, and there was evidence that issues of concern were recorded on logs and reported to the office. We saw examples of care workers in the office contacting people's GPs to relay these concerns and request appointments and home visits for people. Where people had conditions such as diabetes there was information for care workers on care plans about the condition, signs that a person was becoming unwell and how to respond to these.

People had consented to their care by signing care plans and reviews, and there was evidence of discussion of the suitability of people's care packages with them. The provider was working in line with the Mental Capacity Act 2005 (MCA). The Act 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. Care workers had received training in mental capacity as part of their induction.

There were systems in place to record people's consent where they had capacity but were physically unable to sign. This included documenting the reasons why they could not sign and whether another person such as a family member was able to sign to evidence the person's consent. In one case we found that this process was not followed and it was not initially clear why a family member had signed on behalf of the person. However we were satisfied the person had consented as they had signed an earlier care plan and a recent review which evidenced their care was discussed and agreed with the person.

Good

Is the service caring?

Our findings

People we spoke with were positive about the kindness and professionalism of their care workers and the office staff. Comments included, "They talk to me. They try to make my life a bit more bearable" and "They're all good". People commented on their individual workers, with comments including, "[Care worker] is lovely and easy to get on with" and "[Care worker] is above excellent, E-X-C-E-L-L-E-N-T." We observed office based staff responding to people's queries promptly and with courtesy.

The provider also maintained a record of the compliments that they had received about the service, and we found that on 10 occasions in three months people had either made a positive comment about a care worker in a review or had contacted the office to offer a compliment. Examples of these included praising the patience and friendliness of care workers and the way they had been considerate of people's needs. Compliments were also fed back to care workers.

There were systems of review and monitoring which ensured people's views were heard about the service. As part of their reviews, people were asked if any care workers stood out as particularly good or bad. If there were concerns about care workers these were followed up, including removing care workers from a person's care package if they were not satisfied. There was a system of telephone monitoring where people were called to see if any changes were required, if they had enough time to meet their needs and if they were happy with their care workers. People's views were generally positive and were recorded on monitoring forms by office staff. Where there were concerns these were relayed to managers for follow up. We saw one review where a person had recently requested a particular care worker be removed from their package and logs of care showed that this had taken place. In one instance we saw that a person's relative had been sent a care plan and had offered considerable and useful additional detail, which was also attached to the plan.

People's plans contained information on people's wishes for their care and how they preferred to be supported. This included their language needs and preferences for the gender of their care workers. There was information on how people communicated, including the care and support they required with hearing aids and whether people could use sign language or lip read.

There was also information on plans about how to maintain people's independence which aimed to prevent people losing skills by care workers providing support they did not need. For example, one person's plan said that they were able to comb their own hair, and that care workers were to present them with a comb to do this themselves. Another plan showed that a person was able to manage their pad themselves, and needed to be encouraged to do so. Daily logs showed that this was taking place. One person said "my carer lets me do what I can for myself." A care worker told us, "We have to have a balance, we can't just take over. You want them to come back as their old self."

People who used the service told us that they were treated with dignity and respect by care workers. Comments included, "They do respect [my relative]. They close the door for his/her privacy" and "Staff respect my privacy, they cover me with towel." Care worker assessments included recording whether the care worker had greeted the person appropriately, asked permission before carrying out areas of care and

support and explained what they were doing. They then checked whether care workers had taken measures to protect people's dignity.

Good

Is the service responsive?

Our findings

People received responsive care as their care was appropriately planned and reviewed. Comments included, "She asks things like, do you want your hair washed today", "I was involved in my care plan, I had two days to look at it properly before signing for it" and "Overall I'm happy with the service."

Care plans were concise, limited to no more than three pages, and contained summary information about the person and their health needs, their living situation and details about how they liked to be supported. This information was not structured with any clear headings, but contained essential information for care workers based on the person's needs. For example, one person's plan detailed that they had confusion and a history of strokes, and it had clear information for care workers on recognising the signs of a stroke. When people were at risk of falls, there was a concise and clear falls procedure, including the circumstances in which care workers would be expected to stay with the person. This information was followed by a clear plan for each visit, including the best way to access the person's property, greet them and the order in which they wanted care to be delivered. There were also details of personalised information such as when people had two flannels or towels, the repositioning required to prevent pressure sores, and the need for certain calls to be prompt as a person routinely attended church or a day service. In some cases plans demonstrated how people's needs could change based on their current health needs, and prompted care workers to alert the office when this occurred.

Care plans were up to date and accurately described the care and support people received. Plans were reviewed yearly or as required and appropriate changes made as people's needs had changed. One person had had three support plans in four months as their needs had changed greatly in this time. Service monitoring was used to check whether any changes were needed to the timings or plan, whether plans met people's required outcomes and whether a person required a reassessment of their needs. The provider assessed whether people had difficulty reading or writing or any language needs which meant that they might need information provided to them in a different format.

Care workers told us that they had sufficient time to read and get to know people's plans, and that they found the information on them helped them to carry out the correct care. Comments included, "There's plenty of information on there" and "In terms of our work, it covers all the things we should know."

We looked at the records care workers maintained of the care they had provided at each visit. These showed that care was delivered as planned. There was also evidence of care workers taking notes of concerns, such as contacting on call and a person's relative when they were unable to get out of bed.

People we spoke with told us that if they had a concern they would contact the office. Comments included, "There was one [care worker] that wasn't reliable…I informed the office. They were responsive and found me a new carer" and "I've got no complaints and if I did I'd get onto them myself."

We found that when people had made complaints, the provider ensured that these were recorded and included a detailed summary of the complaint and the action taken. Actions included taking statements

from care workers and checking records to see what had happened. For example, a relative had complained that a care worker had not arrived for a call, and actions taken included speaking with the care worker and checking daily logs and electronic call monitoring to find out what had happened. The registered manager had offered an apology where there were failings on the part of the service. In one instance, a person's call was cancelled in error, and the staff member responsible promptly accepted the mistake and apologised to the person which was appreciated by the complainant. We found that although complaints were appropriately addressed, the provider did not always record how this was fed back to the complainant, and whether they were satisfied with how this had been dealt with. The registered manager told us they would make sure this was recorded for future complaints.

Good

Is the service well-led?

Our findings

People we spoke with were positive about the agency as a whole. Comments included, "I get a full service and I'm happy about it" and "I'm perfectly satisfied". Comments from care workers included, "I'm really happy with the new manager, she's really helpful…I love the office, the people there", "I can definitely get hold of a manager or a colleague", "We do have a really good support system, in our office, if we need them we call them; any advice we need we get" and "I have all the support from the office I need."

A director told us, "The first thing [the new registered manager] did was audit the files." Managers had carried out audits between November and December 2017 of people's files. This included checking that people's files had up to date care plans, assessments and risk assessments, that medicines information was up to date and that people had had a recent review and monitoring visit. An audit last year by the local authority had found that some information was missing from care worker's files, and following this managers had also carried out a comprehensive audit of care worker files to check that all information was now in place. A recent meeting with the local authority had confirmed this action plan was now complete.

We found that following these audits managers had taken appropriate action to ensure their findings were acted upon and recorded.

Care logs were reviewed approximately every three months in order to ensure that there was accurate recording. Logs that we checked were audited in line with this requirement, and when there were possible gaps in records these were checked by office staff to make sure there were valid reasons for a visit not being recorded. For example, an auditor had noted that a person's log had a gap of several days, and had confirmed that they were away from home during this time and that their visits were cancelled. Managers had also recently updated the review form to require staff to check the information held in people's houses, and assessors were now checking there was a complete set of information about the service and an up to date care plan present. One person told us, "They come out every four weeks to ask about how the care staff are doing" and "[The manager] visited me about four weeks ago".

Managers had discussed in team meetings their expectations for what care workers needed to record, including the times of visit, the care carried out and that care workers had visually checked any equipment that was in place. We found that even when logs had not been audited these remained of a suitable standard and accurately documented the care that people had received. We did not find any unexplained gaps or illegible logs. Managers were required to submit a weekly report which outlined the levels of reviews, supervisions and complaints and any changes to the service. This was combined with information held by head office to assess their overall compliance with the provider's requirements. The provider had recently rated the branch as 90% compliant. In response to concerns about the on call service lacking local knowledge, the provider had recently restricted their on call services nationwide, which meant the out of hours service was maintained from a West London office which oversaw a smaller number of branches. We saw that information from the on call service was routinely reported back to the branch and recorded on the electronic system for further follow up for managers. There were examples of this information being followed up in supervisions and monitoring visits.

Managers also had systems in place to communicate with care workers and explain changes and outline their expectations. This included sending out memos to all care workers and holding monthly team meetings. We found that a recent team meeting had been carried out three times in one day, which meant that a higher number of staff were able to attend. Team meetings were used to discuss standards around recording and reporting, the safer management of medicines and the use of electronic call monitoring systems. Managers used quarterly spot checks to make sure that staff were on time, appropriately dressed with an ID badge and had an up to date rota on their person which did not display key safe numbers alongside people's names and addresses.

At the time of our inspection the local area had been subject to severe transport disruption due to heavy snowfall and cold weather. Managers had sent a memo to staff outlining some of the precautions they needed to take to ensure their safety and that of the people they were supporting. This included making sure care workers were wearing appropriate footwear and warm clothing, and that people they were supporting were appropriately dressed and their homes were warm. The provider told us that all staff had arrived at work despite the severe disruption, and we observed care workers calling into the office to explain how they would still make their calls and advise of any delays. This information was relayed to people using the service. The registered manager told us, "We have to commend the carers for their commitment and dedication, even in this weather."

The provider was also meeting their obligations to inform the Care Quality Commission (CQC) of significant events that they were required to by law. The registered manager told us that on starting in the role she had reviewed records of incidents and had submitted notifications of any significant incidents that had not already been notified. We found that the provider was meeting their requirement to display their ratings on their website. At the time of our visit they were not displaying their ratings of their previous inspection report in the office, but this was rectified immediately.