Abicare Services 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?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

The inspection took place on 13 and 17 September 2018 and was announced to ensure staff we needed to speak with were available. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults, younger disabled adults, people living with dementia or mental health needs. On the first day of the office site visit the service was providing the regulated activity of personal care to 51 people.

The provider had addressed a period of instability in the management of the service by the appointment of one of their established and experienced managers from another of their locations. The new manager had submitted their application to become the registered manager for the service and this was being processed. 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.

At the last inspection in May 2017 we identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, as the provider had failed to provide people with person centred care. At this inspection we found the requirements of this regulation had now been met. People received personalised care that was planned with them and was responsive to their needs. People's care plans reflected their expected outcomes and any preferences they had about the delivery of their care. The care was regularly reviewed or sooner if their care needs changed. People were supported to pursue their interests where this was commissioned. The service has been rated as requires improvement overall for a second time, as although improvements to the service have been made, further time is required for the manager to complete and embed them across the service.

People were safeguarded from the risk of abuse. Staff had undergone relevant training and understood their role and responsibilities. The provider had identified those staff who needed to update their annual safeguarding training to ensure their knowledge remained relevant and this work was underway. Potential risks to people in relation to a range of aspects of their care had been assessed and where required measures were in place to manage them. Processes were in place to ensure risks were regularly reviewed. Staff had undertaken infection control training and understood their responsibilities in this area. Processes were in place to identify and apply any learning points from incidents.

There were sufficient staff to provide people's care, but following a recent loss of some staff, some people reported their calls were not always delivered in a timely manner and that there was less consistency in their staffing. The provider was aware of this issue and relevant action had been taken to rectify this for people.

People received their medicines from trained staff. Improvements were required to ensure all staff always signed people's medicine administration records in addition to recording in people's daily notes they had received their medicine, to ensure a complete record was maintained.

People's assessments and care planning reflected relevant legislation and guidance. The provider ensured staff had the required skills, knowledge and experience to support the people they cared for. Staff were supported to undertake relevant training for their role. Staff were adequately supported in their role with regular supervisions and spot checks of their practice.

Staff supported people to receive sufficient food and drink for their needs, both during and between visits. Staff worked with relevant agencies to ensure people received co-ordinated care and that their health care needs were met.

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

People told us they found staff to be caring. We observed staff treated people with kindness, compassion and respect when they visited them. Staff were instructed about how they should support people to express their views about their care and how to involve them in making decisions. Staff supported people to be able to retain their independence.

There was a clear vision for the delivery of people's care and the new manager promoted a positive working culture. Staff understood their responsibilities and legal requirements. Processes were in place to engage people and staff with the service. People's feedback had been acted upon and used to improve the service. Processes were in place to enable people to raise complaints about the service and these were investigated.

Overall the processes to assess the quality of the service were effective. However, some required further embedding to ensure they were fully functional. The manager was aware of these issues and had taken relevant action to address them.

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.

People were safeguarded from the risk of abuse. Risks to people had been assessed and managed safely.

Following the recent loss of some staff, some people reported their calls were not always delivered in a timely manner and that there was less consistency in their staffing. The manager was taking relevant action to address this for people, but this will take further time to fully implement these actions across the service and to evaluate their effectiveness.

Staff had not always signed people's medicine administration records, although people had received their medicines. The manager was acting to address this for people, but this will take further time to fully implement these actions across the service and to evaluate their effectiveness.

Is the service effective?

Good

The service was effective.

The provider ensured staff had the required skills, knowledge and experience to support the people they cared for.

Staff worked with relevant agencies to ensure people received co-ordinated care and that their health care needs were met.

People's consent to their care had been sought and legal requirements met. Adjustments have been made to ensure staff accurately referenced how representatives had been involved, when a person lacked capacity to consent to their care.

Is the service caring?

Good

The service was caring

People told us, and we observed, staff were caring.

Staff supported people to express their views and to be involved in decisions about their care.

People's privacy and dignity were promoted during the provision of their care.

Is the service responsive?

Good

The service was responsive.

People receive personalised care that was responsive to their needs. People had been involved in their care planning and the provision of their care reflected their preferences and desired outcomes. People's care was regularly reviewed with them.

People felt able to raise any concerns or complaints and processes were in place to investigate and respond to any issues raised.

No-one was being provided with end of life care at the time of the inspection.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

There was a clear vision for the delivery of the service and a positive culture.

There was now an experienced manager in post to lead the team who understood the issues facing the service. They had prioritised the actions required to address the issues. More time was required to fully implement actions across the service and to evaluate their effectiveness.

Not all quality assurance processes were always applied consistently across the service or were fully effective. The new manager was working to address this for people, but further time was required to embed these new processes and to evaluate their effectiveness.

Care Quality Commission

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Detailed findings

Background to this inspection

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

This inspection took place on 13 and 17 September 2018. Inspection activity started on 11 September 2018 with telephone calls to people who used the service, followed by visits to the office to review records and speak with staff on 13 and 17 September 2018. This inspection was completed by two adult social care inspectors and an Expert by Experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience had experience of caring for older people.

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 reviewed the information included in the PIR along with information we held about the service, for example, statutory notifications. A notification is information about important events, which the provider is required to tell us about by law.

Prior to the inspection we received positive feedback overall from a commissioner of the service. During the inspection we spoke with 11 people and two relatives by telephone and a further two people and one relative during the three home visits we completed during the inspection. We also spoke with two care staff, a community team supervisor, two community team managers, the manager, the compliance manager and the care services operations manager.

We reviewed records which included, 11 people's care plans and seven people's staffing rosters for the period 31 August 2018 to 13 September 2018 and five staff recruitment and supervision records. We also reviewed records relating to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People reported feeling safe with the care staff. One person said, "Absolutely- I always feel safe, equally, whichever person comes here." Several people noted they had received some late or early calls, generally people were understanding about these and all confirmed that any lateness had not unduly disrupted them. People's other comments included, "I know they have had lots of problems with staff leaving." "They are very keen on the medicines and on me taking it properly." "Yes, they all wear smart tops and they always wear plastic gloves for those jobs they need to."

All the staff we spoke with were able to identify the types of abuse people may experience. They understood the correct safeguarding procedures should they suspect a person had been abused. Staff were aware that a referral to an agency, such as the local Adult Services Safeguarding Team should be made, in line with the provider's policy. One staff member told us, "We do get regular training and updates and the management are keen we report anything that might look like abuse." Records showed that 12 of the 24 staff needed to update the provider's required annual safeguarding refresher training, to ensure their knowledge remained current. Records demonstrated the provider was aware of this issue and workbooks had been distributed to these staff for them to complete. The manager had taken relevant action.

Potential risks to people had been screened, identified, assessed and managed for their safety. Risks to people in relation to: moving and handling, bathing, falls, medicines, pressure areas, their finances and home environment had been assessed regularly. Where risks had been identified measures were in place to manage them for the person and relevant guidance was in place to instruct staff. Records showed that staff had been instructed to monitor people's skin and that where they had identified a concern this had been documented on a body map and reported to ensure relevant action was taken. When we spoke to staff they had good knowledge about the potential risks to people and how these should be managed. All staff had completed moving and handling training and one staff member needed to complete their refresher training, arrangements had been made for them to do this. People confirmed they felt safe in the care of staff. Processes were in place to ensure potential risks to people were regularly reviewed.

Staff rostering was carried out electronically and staff generally worked in defined geographical areas with regular rosters. Staff reported they had sufficient time between people's care calls for travel. Processes were in place to monitor that calls took place and to identify and address any potential rostering issues due to staff holidays or sickness.

Some people told us they had experienced a lack of consistency in staffing. Their comments included, "You are never sure who might turn up, it could be anyone" and "We have had a lot of different carers recently." Records showed for the seven people whose rosters we reviewed, five had experienced consistent staffing and two had not, which reflected what some people reported. The compliance manager confirmed that as people had noted, some staff in one area had recently left. The manager had been able to cover people's care calls with existing staff and recruitment was underway. The manager informed us they had not accepted any new packages of care during the past six weeks to ensure there was sufficient capacity for people's existing packages of care. Recent losses of staff had caused inconsistency for some people, but the

manager had acted to address this.

Some people told us their calls could be late. Their comments included, "They are late quite often in the morning and evening, but it doesn't really bother me." "They are often late, but it is not a real problem for me." The compliance manager told us the provider aimed for calls to be completed within 15 minutes either side of the time rostered. Records for seven people, showed that over a two-week period, they all experienced calls that were more than 15 minutes early or late. Although no-one told us this had impacted negatively upon them, people's calls were not consistently delivered at the rostered time. The manager told us they were introducing a weekly staff meeting to enable them to monitor issues such as the timeliness of calls.

Appropriate checks were undertaken before staff began work. Criminal records checks had been undertaken with the Disclosure and Barring Service. This meant the provider had checked that staff were of suitable character to work with people made vulnerable by their circumstances. There were also copies of other relevant documentation including full employment histories, professional and character references, driving licences, motor insurance documentation and notes of staff interviews. The provider operated safe staff recruitment practices to ensure they employed only staff suitable to work with people made vulnerable by their circumstances.

Staff told us they received regular medicines training and spot checks to ensure their competency, which records confirmed. The provider required staff to update their medicines training annually, six staff needed to complete this update and had been issued with the relevant workbook to complete.

Staff assessed with people if they required support with their medicines administration and management and where they did, the type of support required. Risk assessments graded staff interventions from level one (prompting) to four (administration by a health care professional), to ensure people received the level of medicines support they required.

There was clear guidance for staff in people's records with regards to what medicines they were to administer and how people preferred to take them. Where staff applied topical creams, body charts were in place to indicate where they were to be applied. Where people's medicines were dispensed in blister packs, their medicine administration records (MARs) documented the number of tablets staff had administered from the pack and at what time of day. The blister pack was then labelled with the medicine and when they were to be administered. This demonstrated what medicines staff had administered to people and when.

We found gaps in three people's MARs, where staff had failed to initial the MAR to document the person's medicine had been given. In each case when we cross-referenced the person's daily records with their MAR we found the medicines had been administered but the MAR had not always been signed. We brought this to the attention of the compliance manager who was already aware that the logbooks which contained the MARs had not all been audited, and relevant action was being taken to address this for people.

Staff we spoke with told us they had received training in managing infection control, which records confirmed. They were aware of their responsibilities and of its importance. People's care records provided staff with relevant guidance, for example in relation to food safety. Our observations confirmed staff had access to and used the personal protective equipment provided to prevent the spread of infection, such as aprons and gloves, and they followed the provider's 'Infection Prevention and Control' policy.

The provider had an accident reporting policy and an electronic process was in place whereby staff could report any concerns, in addition to completing an incident form where required. Incidents were investigated

by the manager as required and we saw relevant actions had been taken to reduce the risk of repetition. If an incident identified a need for additional training, then this could be arranged. Processes were in place to identify and apply any learning points from incidents.

Good

Is the service effective?

Our findings

People told us the service they received was effective. Their comments included, "I think they are all good and all are very well trained too." "When the nurse came one time to change the catheter and [care worker] was here, [care worker] helped [nurse] quite naturally and [nurse] was impressed." "They make sure I have water and ensure and check I have things to eat nearby and that I am warm- they always put a tea bag in my cup when they leave and put out some milk and a biscuit." "They are mostly very good at what they do and are friendly."

Prior to the provision of care, people's needs were holistically assessed and where available a copy of the person's social services assessment was obtained to inform the care planning process. Recognised tools were used where applicable such as a pressure ulcer risk assessment to assess and manage the likelihood of people developing pressure ulcers. The planning of people's care considered regulatory requirements, legislation and the provider's guidance. For example, a person's moving and handling risk assessment referenced the provider's guidance in this area. Policies to guide staff referenced relevant legislation.

All new staff underwent a six-day induction, allied to the requirements of the Care Certificate, which is the industry requirement for workers new to social care. Training during the induction included areas such as: safeguarding, manual handling, health and safety, infection control, control of substances hazardous to health (COSHH) and food safety. Upon passing the induction, staff then shadowed senior colleagues and underwent practical assessments of their competency until they were comfortable working alone. One staff member told us, "It (induction) was really good and I learnt a lot."

Staff were also able to access further training on: food, fluid and nutrition, equality and diversity, the Mental Capacity Act 2005 (MCA), equality and diversity, mental health awareness and continence care. Staff had also undertaken training in dementia and pressure ulcer awareness. One staff member said, "We have updates every year on a big range of subjects. It helps me a lot I think." Some staff needed to update their training in some areas and this had been arranged. Staff accessed training relevant to meeting the needs of the people to whom they provided care.

Staff underwent face to face supervisions, in addition to practical observations and regular unannounced 'spot checks', carried out by senior staff. On these occasions, staff were assessed regarding their appearance, attitude, and knowledge of the person they were caring for. Staff had been issued with their pre-appraisal forms to enable them to identify the issues they wanted to raise at their annual appraisal in terms of their achievements and future development needs. Staff were satisfied with the support they received.

The manager told us that no-one was currently at risk from either dehydration or malnutrition. However, staff monitored and documented people's food and drink intake and had access to food and fluid charts where required.

People's requirements for staff support with eating and drinking had been assessed and their needs and

preferences regard the support they required documented. There was guidance for staff about what to provide for people and when. For example, one person's care plan stated 'Make breakfast and drink of his choice. Ensure food and drink are left in reach.' Another person's plan noted the type of lunch they wanted provided. A person told us, "Of course, they always make sure that I am all right and always that I have a drink to hand." Where people had a food intolerance this was noted. Several people had a learning disability and in one person's care plan, staff were instructed to 'suggest healthy food choices,' when they went shopping, to guide the person to have the right nutrition.

The provider involved a range of external health and social care professionals in the care of people, such as hospital consultants, community nurses and GPs. Staff had access to electronic systems and communication tools to ensure information could be shared in a timely manner and shared with other agencies where required. Staff worked with relevant services to ensure people received co-ordinated care.

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.

Staff had all undertaken training on the MCA and had access to relevant guidance and information. Where people were able to consent to decisions about their care, they had been fully involved and signed their consent to the care provided.

Staff were able to describe to us how they had reached a 'reasonable belief' that a person lacked the ability to consent to their package of care and the measures taken to establish they lacked capacity and that the provision of care was in the person's best interests. People's diagnosis was noted; therefore, staff were aware of who might potentially lack the capacity to make a decision about their care due to an impairment of the mind or brain. They told us they spoke with the person to determine their understanding of their care needs. Where required, they involved the person's representative to assist them with the assessment. Where they assessed the person lacked capacity, their representative was involved in making the decision as to whether it was in the person's best interests for the care to be provided. This was in accordance with legal requirements. However, having completed this process, staff then asked the person's representative to sign their consent to the care provided. This was not required, where the representative did not hold a valid power of attorney for the person. Following the inspection, the compliance manager provided evidence of how they had changed their wording to more accurately reflect that the representative was not signing their consent to the care provided, but to document they had been involved in a best interests decision as the person lacked the capacity to consent to the care themselves.

Good

Is the service caring?

Our findings

People told us they found staff to be caring. Their comments included, "The carers are lovely." "Yes, all very nice, they are all very pleasant." "They (care staff) are very sensitive and always treat me with respect". "Yes, I am comfortable with all of them and respect for me seems to be their emphasis." "They (staff) are wonderful. They provide everything which is a comfort to me."

People told us that overall staff had sufficient time to provide their care in an unrushed manner. Their comments included, "No, they are never rushing unless they are really under strength," and, "No they aren't rushed usually." A relative said, "Yes todays was not the usual carer but [care worker] had a good chat with my [loved one], it all went smoothly, and I know [loved one] enjoyed the visit." Staff had sufficient time to provide people's care in a personal manner.

New staff shadowed people's care calls, to enable them to get to know people and their needs and preferences, prior to the provision of their care. Staff were also required to read people's full care plans in order to get to know them.

Staff we spoke with felt they worked in a caring manner. One staff member told us, "I can't see the point in doing the job if you don't like people." Staff spoken with knew the people they cared for well and their personal background and preferences. They spoke in a kindly manner about people. Records demonstrated that where people had experienced issues, not necessarily related to their personal care provision, staff had responded promptly in a caring and kindly manner to assist people. Our observations on the first day of the inspection confirmed staff worked in a caring and considerate manner.

People's records contained information to assist staff with their communication needs and any behaviours that could challenge staff. For example, whether people experienced forgetfulness and were likely to repeat questions. It was also noted if people required support to make choices about their daily care such as what to eat. One person's care plan noted, 'Let [person] know what the choices are,' to enable them to be involved in making decisions about their care. Staff were instructed in people's care plans to, 'Ask me if I have shaved' and 'Offer me a choice of what to wear.' Staff understood when people required support to make day to day decisions and had guidance about how to do this.

Staff had identified when people needed or wanted support from their representatives to help them make decisions about their care. Records demonstrated people's relatives were frequently involved in decisions about the person's care where this was what the person wanted.

People's care plans provided guidance for staff with regards to people's objectives in relation to their independence and how this was to be achieved. A person liked to make their own breakfast and their notes stated, 'Assist me to do this but please do not take over.' Another person wanted to be assisted to the shower, where they would bathe themselves. One person said, "They are very caring, but I think there are different ways you can show it. They push me to do things for myself and actually I think that's really caring."

Staff had completed training in equality and diversity. They were issued with 'pocket' cards with key points they needed to be aware of at each visit. These included a statement about the provider's expectation that staff should promote equality, diversity and inclusion during the provision of people's care.

People told us staff upheld their privacy and dignity during the provision of their personal care. One person told us, "They (care staff) are very sensitive and always treat me with respect." We observed staff treated people with dignity and respect.

Good

Is the service responsive?

Our findings

People told us the service was responsive to their needs. Their comments included, "Yes I have a care plan." "I am having a review with them tomorrow, to readjust and work to my changing needs." "They feed my animals for me too." "Yes, I phone management if I have a problem or if I need anything changed." "No, no complaints at all."

At our previous inspection of this service on 24, 25 and 29 May 2017. We found the provider had failed to carry out person centred care planning with people, which was regularly reassessed to ensure their care plans were up to date and reflected their current needs, placing them at risk of receiving inconsistent care or not receiving the care they needed. This was a breach of Regulation 9 Person-centred care of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. At this inspection we found the requirements of this regulation had been met.

Person centred care is when care is planned in consultation with the person rather than by professionals. The resulting care plan should reflect the person's identified needs, goals and expected outcomes from the care provided. People's care had been planned with them and where they required support to participate in this process, the person's representative had been involved.

People's care plans identified their needs, their desired outcomes, any barriers to their achievement and details of how these were to be overcome. For example, one person being supported who had a diagnosed learning disability, wanted support with shopping and meal preparation. There was detailed guidance for staff about how to support the person to achieve these goals. Other people wanted to retain their independence and there was guidance for staff about how to enable them to do this. People's care plans reflected their goals.

Staff were provided with background information about people and what was important to them. People had completed a form, 'Who am I?'. This documented their preferred name, their life so far, family history, home and what was important to them, such as their religion and things that caused them worry. People had a 'relationship circle' which pictorially demonstrated people's family, friends, work, involvement of professionals in their life and the importance of each to the person and their level of involvement with the person.

Staff understood what was important to people and were able to tell us how they had been able to support people to meet their goals, within the care commissioned. For example, one member of staff was going to be supporting a person to go for an evening out. Another person told us how staff took them out to the shops. A relative told us, "I don't get out much because I look after my [loved one] but the carers are there and that lets me pop out." Staff ensured people received personalised care that was responsive to their needs.

Staff had access to detailed guidance about people's care needs and preferences for the delivery of their care in their care plan. There was also a summary sheet, which instructed staff on the core tasks they

needed to complete for the person at each care visit.

The care plans detailed the person's medical diagnosis and what this meant for them. For example, if it caused the person anxiety and how staff should support them. Staff who worked with people with a learning disability were undertaking a distance learning course to build and enhance their knowledge in this area.

Where people lived with medical conditions such as epilepsy or diabetes. There was either a policy in place for guidance or staff had been provided with information sheets about the actions they should take to support the person in the event of a medical emergency.

The compliance manager told us the frequency of people's care reviews depended on their care needs, and that if the person's care needs changed they were immediately re-assessed. Records demonstrated people had regular reviews of their care.

The service ensured that people had access to the information they needed in a way they could understand it and complied with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. Where people had a specific communication need this had been noted. For example, in some people's care plans it was documented that they needed staff support to read instructions or labels. Where people used hearing aids to hear information, this was noted, and staff were required to ensure they had them fitted and they were working.

People were provided with a copy of the provider's complaints policy when they commenced the service. Staff we spoke with were clear about their responsibilities for the management of complaints or concerns. They were aware of the provider's complaints policy and procedures and where to find them. Records showed two formal complaints had been made in 2018. We looked at documentation related to these. They had been managed in a timely and effective manner, in line with the provider's policy. Processes were in place to enable people to raise complaints about the service and these were investigated.

No-one was being provided with end of life care at the time of the inspection. The manager told us once staff had undertaken relevant training, they would be looking at providing this care if commissioned to do so.

Requires Improvement

Is the service well-led?

Our findings

People reported there had been a high turnover of management for the service, which a commissioner of the service confirmed. Most people spoken with did not know who the manager was, although records demonstrated that people had all been sent a letter about the new manager in April 2018 and the new manager had been involved in delivering some care, which had given them the opportunity to meet people. Comments included, "They have improved since the new manager came in."

The provider had a clear mission statement outlined in their statement of purpose which underpinned the provision of peoples' care. The new manager had a good understanding of the culture of the service, having already worked for the provider for six years at another of the provider's locations. They had an established track record with the provider. They appreciated that staff had experienced a high turnover of managers and the impact of this upon staff morale. They had taken relevant action where required to address issues they had identified. They told us they were trying to build a 'whole team ethos.' This involved ensuring that senior staff were clear about both their individual responsibilities, with defined job descriptions and operational areas. They were also building a sense of ownership across the whole team to ensure joint working amongst staff as required to cover staff holidays and sickness for example.

Staff told us they enjoyed working for the manager and some had previously worked for them in another of the provider's locations. One told us, "I'm happy in my work. The office are always helpful if I need to ring in," and another commented, "I do feel listened to by the managers. If I think someone needs extra care I can speak to them and they will listen." The manager described to us how they had promoted equality and inclusion within the workforce, by supporting staff with their individual needs. Staff were positive about working for the service.

The provider ensured regular contact with managers and staff. There were daily electronic communications between head office and the managers, a 'proud moment of the day' to celebrate daily successes and the monthly manager's professional development meetings. They also linked with staff through their weekly provider bulletin, which gave news of fund raising events for the provider's two chosen charities, encouraged staff to set themselves a personal challenge, provided company news and news of local events.

People's views on the service were sought through their reviews, telephone monitoring and the annual survey. Results of the telephone monitoring from September 2018 demonstrated people were satisfied with the service overall and that where two issues had been raised, these had been addressed. We were told verbally that issues identified from the November 2017 client survey had been addressed, but there were no contemporaneous records to confirm this, written details of the actions taken were provided after the inspection. The manager had held staff meetings with staff in both Basingstoke and Aldershot. The plan was for these to be held on a quarterly basis. Staff's views were also sought through the annual staff survey and their supervisions and appraisal. Processes were in place to involve people and staff with the service.

Processes were in place to audit the quality of the service and drive improvements for people. These had led to improvements in the quality of client files, and to care plans and risk assessments being regularly

reviewed for people and required actions taken, in addition to improvements in the standards of record keeping. Staff records had been audited and those we reviewed contained all the required information.

However, not all the processes were fully embedded across the service or effective, as the new manager had had to prioritise their time to ensure issues were addressed in order of importance. Staff meeting minutes from June 2018 showed new arrangements had been implemented for the delivery and collection of people's care log books/medicines administration records (MARs) for auditing. We found people's log books had not always been collected monthly as described, and when they had been, they had either not always been audited, or the audit process was not effective. One person's July 2018 logbook had been audited and no gaps in the MAR found, but we identified two. The manager was aware this was an area that still required improvement. They told us they were about to introduce a weekly senior staff meeting to enable these issues to be addressed, as they arose. On the second day of the inspection, the compliance manager showed us a spreadsheet they had produced following our feedback to enable a more detailed audit of the logbook/MAR records, which was to be supported by staff training. The manager was taking the required actions, but further time was needed, for them to embed these changes across the service and to be able to demonstrate they were fully effective.

Data was produced to demonstrate the time calls were delivered and reviewed, however, this data was not used effectively to consistently identify those whose calls were not delivered on time, so relevant action could be taken, to improve the punctuality of care calls. Although this had not negatively impacted upon the people spoken with, this was an area of auditing that required improvement to reduce the risk of impact on people in future.

Records showed there had been a significant improvement in staff compliance with electronically logging in and out of people's care calls this year. The manager received a weekly report and took relevant action to identify if for example there was an issue such as a problem with a staff member's phone that had prevented them from successfully logging in and out. Records showed that overall 95.5% of calls were logged into. However, our analysis of staff's log-in data for seven people indicated that for these people the log-in success rate for their care calls was lower than 95.5%. This indicated further analysis of individual call log data was required to identify anyone who staff were less likely to be able to log into their calls and any underlying causes. Following the inspection, the compliance manager sent us evidence that the new weekly seniors meeting would also include a check on call log-ins, to address this issue.

We noted that some staff supervision records and some client telephone monitoring records were not available for review. The manager was already aware of this issue and the causes. They informed us of the actions they had taken to ensure all these records were now available and to obtain them, to ensure they were accessible as legally required.

The service worked with local commissioners to plan the delivery of people's care. They ensured they obtained copies of people's assessments from other agencies where available to inform their own care planning.