Westwood Homecare (North West) Limited

Sedgeborough House

Inspection report

47 Sedgeborough Road
Whalley Range
Manchester
M16 7EU

Tel: 01612327535
Website: www.westwoodhomecare.co.uk

Date of inspection visit:
23 March 2016

Date of publication:
05 July 2016

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

We carried out an inspection of Sedgeborough House on 22 and 23 March 2016. The first day of inspection was unannounced.

Sedgeborough House is a domiciliary care service providing personal care and support to people living in their own homes. The service also works closely with healthcare commissioning teams in supporting people who have complex healthcare needs. The hours of support vary depending on the assessed needs of people. Calls range from 30 minutes or more and the service also provides 24 hour live in carers.

At the time of the inspection the service was supporting eight people within the local community. We last inspected the service on 1 October 2013 when we found the provider was compliant in all six standards inspected at that time.

There was 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.

People told us they received safe care, which was reliable and consistent. The service had sufficient staff to meet people's needs, and people were given the time they needed to ensure their care needs were met.

We saw that people were protected from avoidable harm. During the inspection we checked to see how the service protected vulnerable people against abuse and if staff knew what to do if they suspected abuse. There was an up to date safeguarding vulnerable adult's policy in place. Risks to people were assessed and risk management plans were in place. We found that the staff we spoke with had a good knowledge of the principles of safeguarding although electronic training records we saw did not always reflect that everyone had attended formal safeguarding training.

Staff were trained to administer medication. We were told that observation of staff competencies were undertaken by the trainer and the registered maanger but these weren't documented.

The service was not working to the principles of the Mental Capacity Act, 2005 and staff did not receive any formal training on MCA or the Deprivation of Liberty Safeguards (DoLS). The service was not assessing and documenting, where necessary, people's ability to consent to care which meant that care staff were not always clear about supporting people to make their own choices about their care.

The service had robust recruitment processes which included the completion of pre-employment checks prior to a new member of staff working at the service. This helped to ensure that staff members employed to support people were suitable and fit to do so. People who used the service could be confident that they were protected from staff that were known to be unsuitable to work with vulnerable people. Staff knew their

roles and responsibilities and were knowledgeable about the risks of abuse and reporting procedures.

We saw evidence of the induction process, and there was some training provided for caring roles and responsibilities. Not everyone had received training in mandatory elements such as safeguarding and moving and handling.

People were supported with a range of services which enabled them to continue to live in their own homes safely. People we spoke with who used the service and their relatives told us they had been involved in the assessment and planning of the care and support provided and that the service responded to changes in people's needs.

The care records contained information about the support people required. We saw documented evidence of people's likes, dislikes and preferences and records we saw were complete and up to date. Reviews of support packages were undertaken after the initial m onth of support and then on a three monthly basis, or more regularly if changes in need were identified. The service was not able to offer gender-specific choices for personal care and support as there were no male carers employed at the time of our inspection.

We found people were receiving care from care staff who were deployed in a way that met people's needs. Some people who used the service lived alone and staff required the use of a key to access their house. Staff told us keys were appropriately stored in a 'key safe' outside a number of houses and people we spoke with receiving a service were satisfied with the way this was managed.

We found from looking at people's care records that the service liaised with health and social care professionals involved in people's care if their health or support needs changed. The service worked alongside other professionals and agencies in order to meet people's care requirements.

There was an up to date accident/incident policy and procedure in place. Records of accidents were recorded appropriately within people's care files however the recording of incidents needed formalising.

The service had a complaints policy in place and we could see that people using the service were aware of how to make a complaint. Formal complaints were acknowledged and addressed within specified timescales. Staff were made aware of any compliments received by the service.

Staff told us they felt they were able to put their views across to senior staff and to management and we saw examples of this from minutes of meetings and supervision records. The staff we spoke with told us they enjoyed working at the service and said they felt fully supported, listened to and valued.

The service undertook spot checks on staff to observe behaviour and practice but there were no formal audits in place to monitor the quality of service delivery. Feedback from people using the service and their relatives was gained at review and was mainly verbal.

The overall rating for this service is 'requires improvement'. During this inspection we found three breaches of the Health and Social Care Act (HSCA) 2008 (Regulated Activities) Regulations 2014. You can see what action we have told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe

Staff were able to describe the action they would take to protect people if they were concerned people were at risk of harm or abuse.

Recruitment processes were robust. All pre-employment checks were undertaken including DBS checks.

Medication administered to people was administered and recorded appropriately.

Is the service effective?

Requires Improvement

The service was not always effective

Staff did not receive mandatory training in all relevant aspects prior to starting employment.

There were no capacity assessments on care plans and consent to care was not managed appropriately.

Supervision was consistent for all staff.

Staff were pro-active and acted in people's best interests to help them access healthcare and maintain good health.

Is the service caring?

Good

The service was caring

People and their relatives told us they were supported by staff who understood their needs.

Care staff we spoke with demonstrated their understanding of how to maintain people's dignity and independence.

People were encouraged to maintain their independence.

Is the service responsive?

Good

The service was responsive

The provider delivered care that was responsive to people's individual personal preferences.

People told us that staff provided care visits as planned with consistent staff.

Complaints and concerns had been investigated and resolved to people's satisfaction.

Is the service well-led?

Requires Improvement

The service was not always well led

There was no effective system of quality checks and audits in place therefore improvements were not identified or implemented.

Staff felt supported by the registered manager and they felt listened to.

Staff meetings were held and staff could broach their concerns.

Sedgeborough House

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 22 and 23 March 2016 and the first day was unannounced. The inspection team consisted of one inspector. The inspection included visits to the home care agency's premises, to a person in their home and phone calls were made to people, their relatives at home and staff working at the service. The previous inspection took place in October 2013 and no concerns were identified.

Before the inspection we asked the provider to complete 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 in the PIR, along with other information that we held about the service including previous inspection reports and notifications. A notification is information about important events which the service is required to send us by law.

As part of the inspection we reviewed the information we held about the service. This included contacting the care commissioners in Trafford and a healthcare professional who was involved with people using the service.

During our inspection we spoke with the registered manager, a personal assistant, a company trainer and three care workers. At the time of our visit the service was providing personal care and support to eight people, however the support packages of two people using the service were suspended at the time of our visit.

We spent the first day of the inspection at the service's registered address speaking with staff and looking at records. These included four people's care records, five staff recruitment files, 14 staff training records, supervision records, various policies and procedures and other documents relating to the management of the service.

On the second day of inspection we revisited the service's registered address, visited one person who used the service in their own home and spoke with one of their relatives; this visit included observing two staff supporting the person, for example administering medication and with the provision of meals. We looked at paperwork relating to their care after obtaining the individual's permission.

Following the inspection telephone interviews were conducted with a further three staff, one other person using the service and relatives of two other people who were using the service.

Good

Is the service safe?

Our findings

We asked people using the service and their relatives whether they felt safe when the care staff were visiting. People and their relatives had positive things to say about the service. They said, "Yes, I do feel safe"; "Oh, aye, yes. They shower me twice a week and I feel safe"; and
"My relative is safe. (Person's name) is hoisted in a professional way."

We asked people and relatives if they received support from the same care worker or same group of workers. People told us that they were visited by several different care workers but that this group of staff was consistently the same. A relative we spoke with confirmed this and said, "Yes – it is consistent [the staff team]; [person's name] knows who is coming." This meant that people were likely to know their care workers well and that could potentially affect how safe they would feel.

Staff we spoke with demonstrated that they knew how to keep people safe and gave us examples of how they did this such as making sure the person's environment was free from trip hazards; that doors were closed and locked and key safes used appropriately.

We asked the care workers we spoke with to describe the forms of abuse people using the service might be vulnerable to and they could. Care workers also said they would report any suspicions of abuse to their managers. One care worker told us, "If something isn't right then I report it to [registered manager]."

A care worker we spoke with said they had reported a potential safeguarding issue to the registered manager. They told us, "I thought it was serious enough to report it." Another member of staff told us how they had raised safeguarding concerns in a previous employment and said, "I've never needed to do it here – but I would." Staff we spoke with told us they had done safeguarding training but not all of the training profiles we saw reflected this. Staff were able to give examples of types of abuse and knew what steps to take to report allegations of abuse. Care workers did report concerns they had about the people they supported to the registered manager and this was further evidenced in records we saw at the service. This meant that care workers were vigilant in terms of identifying and reporting any concerns they had regarding the people they supported.

We checked the service's recruitment procedures to see if staff employed in the service were suitable to work in the caring profession. We looked at the recruitment records for four care workers. The personnel files we looked at contained appropriate documents in relation to the recruitment process including the original application form, written references, proof of the right to work in the UK and copies of photographic identification. All files we checked had a Disclosure and Barring Service (DBS) check. The DBS helps employers make safer recruitment decisions and aims to prevent unsuitable people from working with vulnerable groups.

We saw that environmental risk assessments had been identified and completed for people using the service and were on care plans where applicable. Examples of environmental risk assessments included various aspects of the home environment, such as the kitchen or the stairway. We saw that following one

risk assessment in a person's home the registered manager had requested that family rearranged the furniture, as the environment in which personal care was to be provided was cluttered. The risk assessment indicated that the person would be more comfortable in a clutter-free environment and moving and handling activities would be safer. This meant that the service was aware of environmental risks when providing care to people in their homes and had assessed and documented them appropriately.

People's risk assessments were appropriately documented. Care plans we looked at contained information in relation to risks that had been identified for individuals. The risk assessment template documented presenting need; risks posed; actions required and desired outcomes. For example, one care plan noted that the person had some swallow difficulties. The risk assessment outlined that carers were to take their time when offering food and to prompt the person with the intake of fluids at regular intervals. This informed care staff about the risk, how to manage the risk and prevent the person from choking.

Some of the people using the service were supported with their medicines. When we visited a person in their own homes we looked at their care plan, after being given permission to do so. We also looked at old medication sheets that had been archived at the office.

Staff had received training on how to support people to manage their medicines. This support was generally provided by prompting or reminding individuals to take their medicines and some packages of care required staff to administer medication. Company policy stated that where staff administered medicine in tablet form this was done from blister packs prepared by a pharmacist and the person's Medication Administration Record (MAR) chart was then completed and signed by staff. During a visit to a person's home we saw that tablets were blister packed and were being administered according to policy.

A record must be kept of all medicines administered to the person the service is caring for using the right paperwork. This information is an audit trail and is vital to other care workers who visit the person as they could administer medication incorrectly causing harm to the person. We saw that the recording of administered medication was consistent and on the correct paperwork.

One person we spoke with was able to self-administer medicines. They told us that staff always asked if this had been taken. This meant that even when staff were not responsible for medicines administration, people were reminded to take them and kept safe from harm.

Electronic call monitoring was being used by the service at the time of our inspection. People and staff we spoke with did not indicate there were any timing issues with visits. Staff told us and we saw from visit schedules that there were no 15 minute care packages. Visits were for 30 minutes or up to one hour in duration. Staff were paid an element for travel time and whilst the registered manager did say that recruitment was an issue, the staff we spoke with did not feel rushed or pressurised when undertaking support visits.

If the service identified, or were made aware of, any timing issues with any calls undertaken people told us they were notified of this. We spoke with a person using the service who told us, "If they are going to be late they ring me up and apologise." We saw evidence that the service had refused packages of care offered to them by commissioners. The registered manager told us that if the service did not have the resources to undertake all visits as per the care plan then these were declined. This assured us that people's safety was being maintained.

All the people using the service received assistance from care workers with their personal care, for example, with washing and dressing and continence. We asked people and their relatives if care workers used

personal protective equipment, such as gloves and aprons, when assisting with personal care. All of the people we spoke with said that care workers did use gloves and aprons. Staff we spoke with confirmed they always had access to personal protective equipment and we saw two members of staff put on clean aprons and a new pair of gloves whilst undertaking a visit and before providing care. This demonstrated that staff were aware of infection control and took measures to prevent cross-infections occurring.

Requires Improvement

Is the service effective?

Our findings

People we spoke with and their relatives told us that the service was effective; they trusted the care staff and told us that they had the right skills and attitude for the caring role. One person using the service told us, "I have no complaints." An elderly relative of another person using the service told us that carers went over and above what was required of them. They said, "They are very good." We asked a relative if they considered the service to be effective. They told us, "Yes. For our needs it fits perfectly."

We saw copies of training records held electronically by the service. These records indicated the training staff had undertaken to date but did not indicate when refresher training was due.

We saw that aspects of training included on these records was limited, with the majority of staff having undertaken mandatory training of safeguarding, medication administration and moving and handling. One member of staff we spoke with told us that she had had no training with the provider but had undertaken moving and handling training in a previous employment. The electronic record we were provided with confirmed that no training had been completed in this employment. The provider must ensure that staff complete all aspects of mandatory training before providing personal care unsupervised so that care is safe and effective.

We saw infection control was one element contained in the induction delivered to staff new to the service. Some people receiving the service had assistance with meals at breakfast, lunch or tea however staff did not undertake any training in relation to basic food hygiene.

This meant that we could not be assured that staff were adequately trained or competent to do all the tasks that were required of them.

The failure to ensure that staff received appropriate and relevant training was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Supervision sessions were undertaken by the registered manager every three months and staff confirmed that these were happening. Staff we spoke with found these meetings with the manager useful and they told us they could raise any concerns they had. Any identified training needs were discussed during these meetings and any personal development requests could be raised.

We saw that a carer had raised an issue in supervision with regards to a visit that required two members of staff to support the person. The care worker had explained that their colleague was turning up late for the call and this was delaying the provision of personal care. This had happened on more than one occasion. The registered manager had noted that this would be followed up to see if any timing issues could be resolved.

The service provided care and support to people who sometimes lacked capacity to make certain decisions for themselves. We looked at what consideration the service gave to the Mental Capacity Act 2005 (MCA) and

checked whether the service was working within the principles of MCA.

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.

One of the care plans we looked at contained the signature of a family member however, it was not clear if the person using the service had capacity. In other care plans, members of the family had been involved in making decisions regarding the care for the individual and had signed their consent, but there was no evidence on file to suggest that people using the service lacked mental capacity.

Family members must have 'lasting power of attorney' for health and welfare decisions before they can consent for the person. When this is in place it indicates that a person has delegated the responsibility to their relative to act on their behalf. A senior member of staff we spoke with was aware of the need for the lasting power of attorney and told us that four family members had this in place for health and welfare decisions. The care records we viewed contained little evidence to show this authority was in place, nor that any assessments of mental capacity had taken place. This information is essential to ensure that decisions made on behalf of people are lawful. The service was not assessing and documenting, where necessary, people's ability to consent to care.

Members of staff we spoke with was not confident with the Mental Capacity Act 2005 or with the rules around consent. We saw some examples in care plans when care staff had alerted the manager with regards to the behaviours displayed by people receiving a service. On one occasion a carer had notified the office that a person was showing signs of confusion. They had arrived at the property and found the front door open and the person still wearing night wear under their day clothes. This showed us that staff were able to respond to changes in behaviour, however they told us and electronic training records confirmed, they had not received formal training in this area.

The service was not acting in accordance with the Mental Capacity Act 2005 and was therefore in breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We saw that the service worked well with other healthcare agencies and professionals, such as GPs, district nurses and speech and language team therapists (SALT).

One care plan detailed involvement with the local SALT team. A person had been on a liquidised diet but had expressed dislike of the food. Care staff had noted that the person had a good appetite and enjoyed the food. They had requested SALT involvement given the person's ability to eat and this had progressed from a mashed diet to the current normal, soft food diet. This meant that staff were observant, listened to people and acted appropriately to involve relevant professionals in the best interests of the individual.

One care plan we viewed noted an appointment at the opticians had been made for a person using the service. Another time a carer had noticed that a person was having difficulty swallowing and was chewing paracetamol tablets. This was reported to the manager who contacted the gp and requested the medication in a soluble format.

A communication book entry we saw detailed a call to a community dietician. The service voiced their concerns over an individual's constipation, due to their diet. We saw that the dietician was aware of the situation, advised the manager to also inform the social worker and was pleased that the provider had

noticed and reported the issue. This showed us that the service supported people to maintain their holistic health and involved other relevant healthcare professionals when appropriate to do so.

Good

Is the service caring?

Our findings

People were very complimentary about the service and spoke very highly of the caring nature of staff. A relative told us about the "great service" being provided and told us, "[Care staff] go the extra mile. [They are] very caring and professional."

We saw that a warm drink was served to a relative whilst lunch was being prepared for a person using the service. We spoke with the relative whilst staff were delivering personal care to a person in another room. The relative told us, "They are very kind. They ask me if I need anything doing too."

A member of staff we spoke with recognised the need to treat people as individuals and how important the caring role was. They told us, "Everyone is different. That person could be [a member of] my family [so] I treat everyone as if they were."

We saw on one visit how two care workers responded to a person they were supporting during a lunch time visit. On entering the property they announced their arrival and spoke to the person immediately asking, "Are you ok [person's name]. Have you had a good morning?" The visit included assisting the person with lunch and involved one care worker giving food and drink to the person.

The care worker chatted to the person whilst undertaking these duties and involved the person wherever possible. The person was not mobile so the member of staff bent down or sat at their level whilst giving lunch to the person. Whilst serving lunch the care worker informed the person what they were doing, listened and gave reassurance. When the person looked to be tiring they asked, "Do you want to carry on with your soup?", and the person replied, "Yes please." Lunch was pleasant and at the person's own pace; staff did not rush with this task.

We saw that a flannel had been placed under the person's chin at the start of lunch and this was used to gently wipe the person's mouth at intervals. The person was kept informed throughout and at the end of the meal thanked the care worker. The individual was provided with a small cup of mouthwash afterwards and asked, "[Person's name] would you like to rinse?" The care worker demonstrated knowledge of the person's needs and preferences and explained to us why this was necessary.

Before leaving the visit staff took practical action to ensure the person was comfortable until the next scheduled visit. Prior to altering the person's position they said what they were going to do, gained the person's consent and then used pillows to maintain a comfortable position for the person. The person confirmed they were comfortable before staff completed paperwork and left the call. This meant that staff involved the person when delivering care wherever possible and acted compassionately when providing care for those most vulnerable.

Care workers treated people with dignity and respect. Staff we spoke with provided us with examples of how they maintained a person's dignity and offered respect. They told us about closing curtains and doors before providing personal care and making sure people were covered up as much as possible whilst

personal care was provided. During our visit to a person's house we heard carers putting dignified care into practice prior to undertaking personal care. One carer spoke with the person and said, "I'll just close the blinds [person's name]. [It will] give you some privacy."

A member of staff told us they had asked a relative of a person using the service to knock prior to entering a downstairs room where personal care was provided. This was requested to preserve the dignity of the person they were delivering the service to and indicated that staff were respectful of the individual.

Staff supported people and encouraged them to be as independent as possible. One member of staff indicated that they would always ask the person if they needed help. "I am always checking [if they need help]. They might want to do it." Another staff member told us they would also give people the opportunity to do things for themselves. They said, "It [independence] is important for people." This was supported by what a person using the service told us. When asked if care workers let them do things for themselves they replied, "Oh yes. If I want to."

As part of our inspection we visited the offices of Sedgeborough House. We found that electronic and paper documents were stored securely and the appropriate checks were in place to ensure that confidentiality was maintained for the people using the service.

Good

Is the service responsive?

Our findings

The registered manager of Sedgeborough House undertook visits to people prior to them receiving a service and carried out an intial assessment of need. We could see that information had been gathered from a variety of sources including commissioners of care, the individual and relatives prior to care visits being undertaken. This was to ensure the service would be able to meet the person's needs.

The manager emphasised that the service did not take on packages unless staff were available and the particular needs of the person could be safely met. Packages of care had been refused in the past given the issues the service had with the recruitment of staff. People who were using the service told us that the staff team was consistent. Rotas were sent out to people the week prior to receiving the support and a relative we spoke with confirmed this. "Yes it's consistent. [Person's name] knows who is coming."

People told us the service was able to respond to requests they made to vary or alter the timing of the visits, for example if they had a prior engagement, a hospital or other appointment. One person we spoke with told us how they were able to change the days or times of support if attending family outings. This showed us the service was flexible and responsive to people's individual requests.

We viewed four care plans at the service's offices and also looked at a care plan in a person's home after obtaining their permission. The care plans mapped out what was expected of carers at each visit and included aspects of care in relation to skin integrity; mobility; continence care; medication and eating and drinking for example. We asked people and their relatives if they had been involved in the development and review of their care plans and people told us they had.

Reviews on care plans were undertaken by the provider on a regular basis and people told us that the care being delivered was person-centred. An initial review was undertaken four weeks after the start of the package to check that the needs of the person were being met. Following that reviews were then scheduled every three months, although care workers we spoke with told us that this could be sooner if a change in need was identified. During a review of care the provider discussed the current care package, any medical changes and noted any comments made by the person or interested parties present at the review. One comment we saw was from a relative who had participated in a review held in December 2015 and said, "Very happy with care that staff are giving [person]."

People did tell us that they were able to make choices about how their care was provided and delivered and that staff respected their decisions. Staff were able to provide examples of the choices people were given when receiving the service. For example people were given the choice of what to eat, what to wear and where to go. One person told us of the choices they were offered at breakfast time. "I can have a cooked breakfast of bacon and mushrooms if I want," they said.

There was evidence that people had been consulted around their likes, dislikes and preferences. We were assured by people and their relatives that they considered the service to be good and care staff knew what was required. Likes, dislikes and personal preferences of people using the service were documented in care

plans. The service recognised the importantance of documenting this information so that care and support provided was personalised, safe and correct for the individual.

There were no personal profiles on the files we looked at but we saw evidence of people's interests and social activities recorded in care plans. The registered manager told us there were plans to introduce life histories paperwork that would provide care staff with a brief history about the person's life, including things that were important to them. This again would provide staff with information about the person, their interests, whether past or present, and could result in more meaningful care and support being provided.

We saw that all employees who worked for the company were female. The registered manager recognised that clients could not currently be offered a choice with regards to the gender of the care worker. This had been an issue as someone had terminated the service in February for that reason. The recruitment of care workers, particularly males, was an on-going issue the registered manager told us and one they were working on to address. People and relatives we spoke with did not raise this as a problem at the time of our inspection.

The service had an up to date complaints policy and procedure which encouraged people to raise any concerns they may have about the service. The complaints process was contained in the service users handbook and signposted people and their relatives to the local authority, Care Quality Commission and the ombudsman. People told us that they knew about the service's complaints procedure and would use it if required. Some people we spoke with said they never had cause to make a formal complaint or raise a concern.

We saw that the last complaint, made in January 2015, had come from two family members of a person receiving a service. The formal complaint expressed concern about the attitude and behaviour of a member of staff and requested that the carer did not provide personal care for their relative again.

We saw that the provider had taken appropriate action in relation to the complaint, having investigated the incident and taken disciplinary action against the member of staff. We saw an email on file that had been sent to the complainants conveying the carer's apologies. This meant that the service was effective in ensuring people and their relatives were aware of the complaints process and that systems were in place to deal with any complaints made.

If a compliment was received by the office then staff were made aware and it was shared amongst the team. A recently received compliment displayed in the office was from a family and the comment inside the thank you card read, "Your staff are exceptional." Informing staff about positive feedback from people and their relatives kept morale high and raised the confidence of staff. Staff we spoke with were proud of the compliments the service had received.

Requires Improvement

Is the service well-led?

Our findings

We asked people and their relatives if they thought that Sedgeborough House was well managed; people we spoke with told us they thought it was. People told us, "It's better [than a previous service]. I'm happier"; "I think so;" and "I have no issues. It's fine." One relative told us how the service, "inspires confidence in family members ", because it was run so well.

As part of the inspection we asked the registered manager how the service was audited for safety and quality and how improvements were identified and implemented. We saw spot checks of staff on file, the most recent one being completed in July 2015. These spot checks were unannounced and covered a range of aspects including: checks on the member of staff's appearance; use of personal protective equipment; uniform being worn; and assessment of staff practice.

These visits were undertaken by the registered manager and also provided an opportunity for checks on the person using the service. These documented checks meant that the service was carrying out checks on employees and also ensuring that people using the service were satisified with the quality of care being provided.

We found no evidence however of any formal audits with regards to the administration of medicines, recording of care or the duration of care calls. Whilst we were told that staff were observed with regards to their competencies with medicines administration these were not documented. We could not be confident that any errors in staff practice had been identified and brought to their attention. We saw that old paperwork had been collected from people's homes and archived at the office but no audits had been undertaken on the quality of the recording and completeness of records. This meant that any issues and errors with these had not been identified and had therefore not been rectified.

When an incident occurred within the service a report of the incident was logged in the communication book. In the example we saw staff had acted appropriately having notified the registered manager but there was no formal documentation of incidents that occurred within the service. As the service did not have an effective system in place for the logging and follow up of any incidents this meant that the registered manager did not have oversight of all the incidents and accidents that occurred at the service and therefore could not respond with corrective actions if necessary.

At the time of our inspection, the service did not have an effective system in place to monitor and assess the quality of the service. This was a breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We also asked the staff what they thought of the registered manager; they told us, "I think [person's name] is a good manager"; "I feel supported"; "The manager listens to us" and "We work as a team." One member of staff indicated that the registered manager was fair and said, "If there are any problems they do listen. [Registered manager] does support us." Another staff member indicated that there had been, " a few crossed wires" regarding working hours and staffing levels but then added, "[the] company is ok."

Staff meetings were held and were well attended. Staff told us they felt they were able to put their views across to management and we saw examples of this from minutes of meetings. The last staff meeting had taken place in November 2015. Areas discussed at the meeting included confidentiality; care plans; medication course and teamwork. Staff were also instructed at the meetings to call into the office and read care plans and look at relevant information for those people new to the service. It was documented and staff were reminded that a care plan was a legal document that could be used in a court of law.

Other types of meetings included one to one supervision sessions with members of staff. Staff told us they felt comfortable raising any personal issues or concerns in these sessions. The manager operated an open culture and was approachable we were told. "We can speak out," a member of staff told us.

Communication from the provider between the people receiving a service and their relatives was good. We saw that the provider had informed all clients of the pending inspection from CQC in a communication sent out in January. Whilst people we spoke with had not received an official annual questionnaire from the service to ask for their feedback, they had no concerns with the service. One person told us the feedback they provided was regular and verbal, both to care staff and the registered manager. A relative told us they were able to provide feedback and voice any concerns at the review meetings, held every three months. A second relative spoke highly of the service and told us, "I've met the [registered] manager. I'm very happy and so is [person's name.]"

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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 11 HSCA RA Regulations 2014 Need for consent Care and treatment of people must only be provided with the consent of the relevant person. Capacity assessments had not been undertaken and the service was not operating in accordance with the Mental Capacity Act 2005.

Regulated activity	Regulation
Personal care	Regulation 17 HSCA RA Regulations 2014 Good governance The service had introduced spot checks on staff but formal audits of the service were limited or not documented. Systems were not in place to fully assess and monitor the quality of the service and therefore any improvements had not been identified.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing Staff did not always receive training in mandatory subjects prior to commencement of employment. Staff were not adequately trained in all aspects of the caring role.