Homebased Care (UK) Limited

# Homebased Care (UK) Ltd- Coventry

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

Homebased Care Coventry is a domiciliary care agency which provides personal care to people in their own homes. At the time of our inspection the agency provided care and support to approximately 69 people and employed 50 care staff.

At the last inspection of the service in July 2015 we rated the service as Good. Since the last inspection the provider had changed their registration details. This meant the service was required to be re-inspected and rated.

We visited the office of Homebased Care Coventry on 20 April 2017. We told the provider before the visit we were coming so they could arrange for staff to be available to talk with us about the service. The visit was supported by the organisations quality manager and the compliance manager, who was also the nominated individual for the service.

A requirement of the provider's registration is that they have a registered manager. There was a registered manager in post at the time of our inspection. 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 and associated Regulations about how the service is run. The registered manager was unavailable on the day of our visit.

There were systems and processes to protect people from risk of harm. Staff understood their responsibilities for keeping people safe and for reporting concerns about abuse or poor practice within the service. There were procedures to manage identified risks with people's care and for managing people's medicines safely. Staff's suitability for their role was checked before they started working in people's homes.

There were enough staff to deliver the care and support people required. Staff received an induction when they started working for the service and completed regular training to support them in meeting people's needs effectively. People told us staff had the skills to provide the care and support they required.

The managers and staff followed the principles of the Mental Capacity Act (MCA). Staff respected decisions people made about their care and gained people's consent before they provided personal care.

People had different experiences with the times staff arrived to provide their care. Some people said staff arrived around the time expected; others said they had experienced late or missed calls. Some people told us the service they received at weekends was not as consistent or reliable as the service they received during the week.

Most people told us staff stayed long enough to provide the care they required and people said they received care from staff they knew. Staff we spoke with visited the same people regularly and knew how

people liked their care delivered. Care plans provided guidance for staff about people's care needs and instructions of what they needed to do on each call.

People told us staff were kind and respected their privacy. Staff felt supported to do their work effectively and said the managers were approachable and knowledgeable. There was an 'out of hours' on call system, which ensured management support and advice was always available for staff.

People knew how to make a complaint, and people and staff said they could raise any concerns or issues with the managers.

Quality assurance systems were in place to assess and monitor the quality of the service. These included asking people for their views about the service through telephone conversations, visits to review their care and annual questionnaires. Feedback gathered by the provider from people and their relatives was used to make improvements to the service. There was a programme of other checks and audits which the provider used to monitor and improve 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.

People felt safe with staff, and there were enough staff to provide the support people required. Staff understood their responsibility to keep people safe and to report any suspected abuse. People received support from staff who understood the risks associated with their care and knew how to support people safely. The provider checked the suitability of staff before they were able to work in people's homes. People received their medicines as prescribed.

### Is the service effective?

Good

The service was effective.

There was a programme of induction and training for staff to ensure they had the right skills and knowledge to support people effectively. The managers followed the principles of the Mental Capacity Act and staff respected decisions people made about their care. Where people required support, staff made sure people had enough to eat and drink and were referred to healthcare services when required.

### Is the service caring?

Good

The service was caring.

Most people received care and support from staff they knew and who understood their individual needs. People were supported by staff who they considered were kind, caring and respectful. People said the support they received maintained their independence so they could remain at home.

### Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's care needs were assessed and staff understood people's individual care and support needs. People's care was planned around their personal preferences but people said the times they received their care was often much later than

expected. People knew how to complain if they needed to.

## Is the service well-led?

Good

The service was well led

Most people were satisfied with the care they received and spoke positively about the registered manager. Staff received the support and supervision they needed to carry out their roles and felt confident to raise any concerns with the managers. The provider had an experienced management team that regularly reviewed the quality of service people received.

# Homebased Care (UK) Ltd- Coventry

**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 was 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.

The office visit took place on 20 April 2017 and was announced. We told the provider before the visit we would be coming so they could arrange for us to speak with care staff. The inspection was conducted by one inspector 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.

Prior to the office visit we reviewed the information we held about the service. We looked at the statutory notifications the service had sent us. A statutory notification is information about important events which the provider is required to send to us by law. We contacted the local authority commissioners to find out their views of the service provided. Commissioners are people who contract care and support services paid for by the local authority. They had no new information to share about the service.

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 were able to review the information in the PIR during the inspection. The PIR was an accurate assessment of how the service operated.

The provider also sent a list of people who used the service; this was so we could contact people by phone to ask them their views of the service. We spoke with 16 people by phone, eight people who used the service and eight relatives, one of whom contacted us after the office visit to share their views about the service.

During our visit we spoke with three care workers, a care co-ordinator, an administrator/co-ordinator, the

provider's quality monitoring officer and the compliance manager who supported the inspection in the absence of the registered manager. We reviewed three people's care records to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the service's quality assurance audits and complaints.

Good

# Is the service safe?

## Our findings

People were supported by staff who understood how to protect them from the risk of abuse. Staff understood the type of concerns they should report and how to report it. For example, they told us they would look out for changes in people's moods and unexplained marks or bruises. One staff member told us, "We have safeguarding training so we know what to look out for. If I had any concerns I would ring the office and report it." Staff were confident any concerns they reported would be acted on by the managers. The managers understood their responsibility for reporting any safeguarding concerns to the local authority safeguarding team and to us. Staff told us the provider had a 'Whistleblowing' policy and procedure so they could share any concerns about other staff's practice. A staff member told us, "If I saw any care worker doing anything I thought was unsafe or if they spoke to a client in a way that wasn't respectful I would tell them, and I would let the managers know."

People said they felt safe using the service as they had regular care workers who stayed long enough to provide the care and support they needed. People told us, "They do always stay for as long as is necessary to get everything done." and, "I've never known them to go before their time is up, there are so many tasks to get done that the time just races by."

There was a procedure to identify and manage risks associated with people's care. People had an assessment of their care needs completed at the start of the service that identified any potential risks to providing their care and support. For example, where people required help to move around, risk assessments detailed how they should be moved, the number of staff required to assist the person, and the equipment used in their home. Relatives told us staff knew how to move people safely. Comments included,"[Name] has a hoist which the carers use. They do seem to know what they are doing with it." And, "[Name] needs to use a stair lift to get up and down stairs and they all support her very well."

Where people were at risk of skin damage due to poor mobility, care plans instructed staff to check skin for changes, report any concerns to the GP or district nurse and to inform the office staff. Completed records of calls showed care staff carried out checks and applied creams to prevent skin damage as advised.

The provider's recruitment process ensured risks to people's safety were minimised. The provider made checks on staff prior to employment, to ensure they were of a suitable character to work with people in their own homes. Staff told us and records confirmed, they had their Disclosure and Barring Service (DBS) checks and references in place before they started work. The DBS helps employers to make safer recruitment decisions by providing information about any criminal record a person may have and whether they are barred from working with people who use services.

The managers and care co-ordinator told us there was enough staff to allocate all the calls people required. All the staff we spoke with confirmed there were enough staff and that they were not asked to cover additional calls to people unless staff were off at short notice. One staff member told us, "Yes there is enough staff, if someone phones in sick they, [managers] know which staff has availability to cover." Staff said they had weekly rotas that informed them the people they would be visiting and the time they should

arrive. The provider also used an electronic system to allocate visits to people. The system allocated visits to staff at specific times and included the time allowed for the visit to take place. The compliance manager explained that not all people who used the service had electronic monitoring because some people did not want staff to use their telephone, and others did not have telephone lines for staff to use. They told us the management team were looking at how the number of people who had electronic monitoring could be improved, so they could be assured staff were in the right place at the right time.

Care staff were provided with 24 hour support from managers. The provider had an out of hour's on-call system to support staff when the office was closed. One staff member told us, "I use the on call if I need help or advice, it works well. If they don't answer straight away they always phone you back." This reassured staff that there was always someone available if they needed support.

We looked at how medicines were managed by the service. Most people we spoke with administered their own medicines or their relatives helped them with this. People who were supported by staff told us their medicines and creams were administered as prescribed. Comments from people included, "My carers get my tablets out for me and they write in the chart once I've taken them," and "My carers give me all my tablets with a drink and then they fill the records in so my family know I've taken them." Two people told us the times care staff arrived meant they did not always have their medicines at the same times, for example, "The problem is more about the timings of calls varying so widely, that my tablets get taken sometimes at 8am, or 9am or even as late as 10am. Thankfully the doses don't have to be strictly timed, but they are supposed to be spaced out."

Staff told us, and records confirmed; they had received training to administer medicines and had been assessed as competent to give medicines safely. Staff we spoke with were confident they knew what to do. They said they checked medicines against a medicine administration record (MAR), recorded in people's records that medicines had been given and signed to confirm this on the MAR.

MARs were checked by staff during visits and were returned to the office monthly to be checked for any errors. The completed MARs we looked at in the office had been accurately signed and dated by staff when medicines were administered.

Good

# Is the service effective?

## Our findings

Staff told us they completed an induction programme and training to ensure they had the skills they needed to support people. Staff told us their induction included working alongside an experienced member of staff, and training courses tailored to meet the needs of people they supported. Staff spoke positively about the training and said "it equips you to do your job." The compliance manager confirmed staff induction training was based on the Care Certificate. The Care Certificate sets the standard for the skills and knowledge expected from staff working in a care environment.

People confirmed staff had the skills to provide the care they required. For example people who required equipment to move around said staff used this safely. Relatives told us staff provided effective care, comments included, "[Name] has a regular carer called [staff name] who is wonderful. Mum unfortunately, has very little speech, but she has got to know Mum so well that she can tell by her mannerisms, how she's feeling and what she needs." Another told us, "[Staff name] is excellent with Dad. She notices things like the smallest red mark and importantly, she'll tell me about it."

Managers kept a record of staff training, which included dates when refresher training was due to be renewed. The compliance manager confirmed staff received regular training to keep their skills up to date and provide effective care to people. This included training in supporting people to move safely, medicine administration and safeguarding adults. Staff also received training in specific conditions such as dementia. This was to ensure people received care from staff that understood their medical conditions.

Staff received management support to make sure they carried out their role competently and effectively. Staff told us in addition to completing the induction programme and refresher training; they had regular observations of their practice to make sure they understood the training and put this into practice effectively and safely.

We checked whether the provider was working within the principles of the Mental Capacity Act 2005 (MCA), and whether any conditions on authorisations to deprive a person of their liberty were being met. The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA.

The managers understood their responsibilities under the MCA. They told us there was no one using the service at the time of our inspection visit that lacked the capacity to make all of their own decisions. Some people lacked capacity to make certain complex decisions, for example how they managed their finances. Those people had somebody who could support them to make decisions in their best interest, for example a relative.

Staff completed training in the MCA and staff we spoke with knew they should assume people had the capacity to make their own decisions, unless it was established they could not. All the staff we spoke with said people they visited could make everyday decisions about their care, or had given consent for relatives to support them to make these decisions. Staff knew they should seek people's consent before providing care and support. People confirmed staff made sure they were in agreement before commencing care. One person told us, "Yes, they'll always ask me if I'm ready to make a start." A relative told us, "I can hear the carer upstairs asking her if she's ready to start or if she would like a cup of tea first."

People who required assistance with meals and drinks were supported to have sufficient to eat and drink. Most people we spoke with were able to prepare their own food or had relatives who helped them do this. Where people required staff to assist them with meal preparation, this was recorded in their care plan. People who had assistance from staff to prepare their meals were satisfied with the service they received. One person said, "I have [brand name] so my carer will tell me what there is, and then I'll choose what I fancy to eat." A relative told us, "I will plate up a meal for [name] before I go off to work. She decides what she would like and the carer will then microwave it for her later on." People and their relatives told us staff asked if they wanted a hot drink whilst they were there and made sure they had a cold drink available before they left. For example, "My carer sorts me out with a hot drink while she's here and she'll leave me a small jug of juice for the rest of the morning, on the table next to my chair." Another said, "I've always got some drink by my chair during the day and my carer will fill up a small flask for me when I go to bed." One person told us how care staff encouraged them to have sufficient to drink, "I don't really feel like drinking much these days, but the carers always encourage me to just have one more drink." This supported people to remain well hydrated.

The provider worked in partnership with other health and social care professionals to support people's health. The managers told us people were referred to their doctor, district nurse or other health professionals when needed. All the people we spoke with arranged their own health appointments or had family who supported them to do this. Staff told us, if a person was unwell during their call, they would ask the person if they would like to see a doctor and call the GP. They would also inform the family and contact the office to let them know, so they could follow this up if needed. Records showed health professionals such as GPs and district nurses were consulted where concerns had been identified.

Good

# Is the service caring?

## Our findings

Most people we spoke with told us staff were kind and caring. One relative said, "The regular carers couldn't be more caring. They do extra jobs without needing to be asked, they tidy up after themselves and they are exceptionally kind to her." Another told us, "[Name] carer is a stickler for ensuring he's in clean clothing, at least at the start of the day. She spots things that I even miss. I really appreciate her attention to detail, because before he fell ill, he was such a person who would have been mortified to think that he wasn't dressed immaculately all of the time."

Staff told us what being caring meant to them, they said, "It's about letting people do things for themselves and making sure people are safe and feel confident to trust me." And, "It's giving people time, listening and respecting them, and always having a smile for them." Another said, "Being compassionate and observant and generally looking after people."

People told us staff maintained their privacy and treated them with respect. One person said, "The first job my carer does of an evening, is close all the curtains and put the lights on so nobody can be nosey and see what we're up to." Another said, "My carer lets herself in with the key safe. She'll always ring the bell anyway and then call up the stairs on her way in so I'm not panicking about who's coming through the front door."

Most people we spoke with said their care was provided by staff that they knew and liked. Staff said they visited the same people regularly so had opportunity to form friendships with people and their families. Staff said they had sufficient time allocated to people's care calls and did not have to rush. One staff member told us, "I have enough time allocated to do what I need to, I can take my time. If I needed more time I would let the office know." People confirmed staff did not rush and said staff had time to sit and chat. However, some people told us some staff were not very talkative, for example, "I always enjoy a chat with my regular carers. Some of the others I see can hardly say a word to me." And, "There's one lad who honestly, doesn't say a single word from the minute he comes to the moment he goes."

Some people told us communication was sometimes difficult with staff whose first language was not English. One relative told us, "Please don't think I'm saying this because I'm racist, because I'm not. But [name] really struggles with a lot of the carers because they have such strong accents and then to compound matters, they struggle with [name] strong regional accent. So at times, I just despair about how they get through things in one piece, probably more by luck than judgment."

We asked care staff if people had raised concerns about communication with them. They told us that some people had, they went on to say where people's hearing or communication skills were impaired, communication with some staff was sometimes more difficult for people. One staff member told us, "Some people say they can't understand some staff, mainly from African backgrounds, but sometimes I think they could do more to help themselves understand. One person should wear a hearing aid but refuses to do this. I don't have any problem understanding care staff."

The compliance manager told us as they employed staff from diverse backgrounds they were often able to

meet people's cultural needs with staff who spoke the same language. They said in some cases English was not the staff member's first or second language. To make sure care staff whose first language was not English could carry out their role, the provider completed basic literacy tests during recruitment. The managers told us all the staff had sufficient knowledge of English to understand what they should do and how to report any concerns. They said all staff completed training, such as the Care Certificate and vocational qualifications where they needed to record answers and have their competency assessed before they could pass the training. We spoke with three care staff from different backgrounds during our office visit; all three could understand and communicate well in English.

People told us the care and support they received helped them to maintain independence and to continue to live at home. One person told us, "If it wasn't for my carers, my family would have moved me into a care home by now. But I like my limited independence and this is my family home, so I want to stay here as long as I can."

People said they were involved in their care and in decisions about how this was provided. One person told us, "I am certainly able to decide things like which days I would like to have my shower."

Requires Improvement

# Is the service responsive?

## Our findings

There was a mixed response from people when we asked if staff arrived on time. Most people said they had experienced late calls. People told us, "When I started with them, I asked for someone to call about 8am. Unfortunately, they hadn't enough staff to do that and it now seems to be getting later and later. The other day it was nearly lunchtime when they came to get me up." Another said, "When we have the regular carers, they usually arrive on time or thereabouts, but at weekends or when our regular carers are off, they can arrive at any time between 8am and 11am. It makes it impossible to plan anything." A relative told us, "Mum goes to the day centre twice a week, but I've now cancelled the morning call for those two days, because the carers were getting later and later. I now get her ready those two mornings." Another relative said, "When we started, we were asked what time we would like the visits and whether we preferred male or female carers. The only problem with that is we now know the timings were really only intended as a guide, not an accurate time for a visit at all."

A relative told us they had no concerns about the standard of care provided but, "Times are terrible, particularly the morning call. It's supposed to be between 8-9am but could be as early as 6.45am and 7.15am, much too early. I did contact the office and we had a review about a week ago. I have been on holiday and just returned so I'm not sure if this has improved."

We spoke with the managers and care coordinators about timings of calls. The managers told us, two of the most important aspects of support for people were continuity of staff and consistency of calls. They told us the consistency of calls had improved lately and that people's calls were scheduled to regular care staff at consistent times. They said there was enough staff during the week and at weekends to allocate the same calls to staff.

The managers said not all people used the electronic call monitoring system, and where people had this in place some staff did not always use it to log into people's homes. This meant the office could not monitor these calls. This was an area the provider had identified for further improvement. Their PIR told us, "Homebased Care (HBC) recognises the importance of ensuring that services are delivered in line with service user preference and contractual requirements. HBC introduced electronic log early in 2016 with some degree of success. HBC seeks to build on its achievements in this area by ensuring that all colleagues understand what is required. This will be achieved through closer monitoring of people planner outputs and staff supervisions."

A care coordinator told us, "All calls are scheduled on 'people planner' (the system the provider used to plan and monitor people's care) but some time sheets need tweaking so they are in 'run' order. This will make it easier for staff to follow the timesheet." They went on to say they had almost completed updating all staff timesheets.

One relative told us their family member had received several missed calls in March 2017. We looked at the person's call schedule for March and the records staff had completed during calls in the person's home. We identified seven dates, mainly weekends where there were no entries from staff. The managers checked the

dates on the computer call planning system; this showed a family member had cancelled these calls so visits had not been provided.

Most people told us they had regular care staff who knew their preferences and how they wanted their care provided. However people told us the service was not as responsive when they had other care staff. Comments from people included, "My regular carers do, [know their preferences] but I'm not sure about the rest of them. They don't really have the time to get to know me really well, and I only see them once every few weeks so that doesn't help either." Another said, "If I only saw my regular carers, I'd happily say yes, but the other carers I see really don't get to know me at all, nor I them." And, "I cannot fault my regular two carers, they are brilliant, but not all the carers reach their standard…. It's almost impossible to get a word out of a few of them. They go away leaving me feeling mildly depressed!"

We looked at the call schedules for the three people whose care we reviewed, and the rotas for the staff who visited them. People were allocated regular staff at consistent times. Although action had been taken to allocate regular care staff to people, and records we looked at confirmed people received care and support from the same care staff, some people indicated they would like more consistency. Comments included, "If I could have my regular carers all the time, I'd have no problems at all," another person said, "I'd just like to have regular carers all the time, then I would have no complaints because they manage their timings so much better. I've talked to [registered manager] about it and I know he can't just materialise carers out of fresh air."

The managers and care co-ordinators had a good understanding of each client and what care they required. They told us where possible they tried to match care workers to client's needs and personalities. The co-ordinators provided care calls to people if their regular staff were off at short notice. They said this assisted them in carrying out quality checks, reviewing call times were sufficient, and if there were any changes to people's care needs they had not been made aware of.

We looked at three people's care files. These showed an assessment of people's needs had been completed before the service started and a care plan had been compiled following the assessment that identified how people's needs were to be met. Care plans contained details of what staff needed to do on each call and included people's preferences. Information in care records was individualised and included people's health conditions such as Parkinson's disease and provided information for staff so they had more awareness about the condition. Care and support was planned for each person based on their individual needs. Care records had been signed by the person, or their representative, where they were unable to sign records themselves.

Most people were aware they had a care plan and other information kept in the folder that staff signed after each visit. People and relatives told us, "I met [registered manager] with my daughter before I started having care from them and he put together some paperwork setting out all my care needs. It's in my folder where the carers sign each day." And, "When [registered manager] first came to visit us, he put together a care plan setting out everything [relative] needs help with. We had a long chat with him about it. I know it's in [relative's] folder, but I'm not sure whether he was asked to sign it or not."

Staff made a record of the care they had provided on each call, and signed the record to confirm it was accurate. Staff told us they had an opportunity to read care records and the communication book [daily records] at the start of each visit to a person's home. The daily records gave them additional information about how the person was supported and provided staff with 'handover' information from the previous member of staff. A staff member told us, "I visit the same people regularly so I don't always read the care plan, but I always read the communication book. If there had been any changes the office would let me

know and I would read the care plan."

Staff said any changes they identified with people's care needs were referred back to the office staff for review and re-assessment. For example one staff member said, "When people get slower or they become a bit unsteady on their feet, it takes more time to provide their care. I refer this back to staff in the office and they contact the social worker for more time or for equipment to support them mobilise." Staff told us office staff would telephone them to let them know about any changes and updates to the care plan.

We asked people if their care plan was reviewed regularly to ensure their needs were being met in accordance with their preferences. Most people said they were, they told us, "[Registered manager] comes to do a review about once a year and I also see him at other times because he fills in for carers when they are short." And, "I saw [registered manager] just after Christmas and we reviewed my care. He also comes as a carer from time to time when there's a shortage of other carers."

Care plans we looked at had been reviewed and updated at regular intervals, consistent with the provider's procedures, or when people's needs had changed to ensure people's needs were still being met.

We looked at how complaints were managed by the provider. People we spoke with knew how to complain and said they had complaints information in their home. They told us, "I remember seeing a complaints leaflet when I started with the agency, I think it's in my folder now." And, "I certainly know who to get hold of to make a complaint to."

Staff knew what to do if people wanted to complain and that there was complaints information in people's homes. One staff member told us, "I would tell the person to ring the office. I would remind them about the complaints information in their folder; it has numbers who they can contact." Another said, "I would tell them to contact the office, I would offer to do this for them if they wanted me to."

We looked at the record of complaints in the complaints book. There were procedures in place to log and analyse complaints and feedback, to see if there were any common trends or patterns. This supported the provider to learn from the feedback they received, for example late calls. Records showed people who raised concerns were contacted in a timely way by the registered manager and efforts were made to resolve things to their satisfaction.

Following our office visit a relative contacted us to share their views about the service. They told us they had recently made a complaint as care staff had recorded the wrong times they had left their family members home in the communication book, and that this was being investigated. We contacted the compliance manager as this complaint had not been recorded in the complaints log. The compliance manager updated us on the progress of the investigation and advised the records of the investigation had been at their Birmingham office, and that this had now been rectified.

Good

# Is the service well-led?

## Our findings

The service had a registered manager who was supported by a management team that consisted of two care co-ordinators, an administrator/co-ordinator and an administrator. The Coventry management team were regularly supported by the organisations management team which included a compliance manager, quality managers and a professional development manager.

The provider and registered manager understood their responsibilities and the requirements of their registration. For example, they understood what statutory notifications were required to be sent to us and had submitted a provider information return, (PIR) which are required by Regulations. We found the information in the PIR reflected how the service operated.

The management team and staff we spoke with had a clear understanding of their roles and responsibilities and what was expected of them. Staff told us they were given information about the provider's policies during their induction when they started working for the service. Staff said the provider's policies supported their practice. For example, all staff knew they could not use a hoist or give medicines unless they had been trained to do this. They also knew about the provider's whistleblowing policy for reporting concerns about other staff practice.

People and their relatives knew they could contact the office staff if they needed to. The compliance manager told us the managers and other office staff had a good relationship with people who used the service, they told us "Clients do contact the office, and as they know our names and faces they are more likely to pick up the phone to discuss anything."

Most people were satisfied with the service they received. Everyone we spoke with knew who the registered manager was. People spoke positively about the registered manager, but thought the service needed more staff, particularly when their regular care worker was off. People told us, "[Registered manager] does his best and I feel sorry for him because all I ever do is moan at him. If he could recruit staff as dedicated as he is, there wouldn't be any problems." And, "[Registered manager] is always very approachable and I have a lot of time for him, but bless him, he needs to recruit some more carers."

The PIR stated, "Senior managers have worked closely with operational managers to ensure that 'People Planner' is fully utilised for the management of allocation, rostering and timesheets for care staff. Managers are planning rotas four weeks in advance to create opportunities for a more effective way of managing unplanned absences."

The provider had identified call times to people needed improving and had taken action to make sure people were allocated regular care staff at consistent times. The PIR told us, as a result of learning from the complaints received, the provider had taken steps to improve the service to minimise late calls. This included: increasing the volume and frequency of spot checks and observational supervisions, and reintroduced electronic call monitoring. The managers continued to monitor late and missed calls. Any late or missed calls were recorded, including the reason for these and any action taken in response.

The compliance manager told us their biggest challenge during the last 12 months had been the recruitment and retention of staff. The PIR told us, "HBC have a rolling recruitment programme to ensure we have sufficient capacity over and above planned care hours," and that, "having a flexible approach to work life balance for staff had contributed to improved staff retention."

The compliance manager told us they promoted an open culture by encouraging staff to raise any issues of concern. They said there were opportunities for staff to do this at any time, by phoning or visiting the office, through regular one to one meetings or through regular team meetings.

Staff told us they had regular meetings with a manager to make sure they understood their role. Staff had an annual appraisal to review their performance, and discuss any personal development requirements. Staff told us they enjoyed working for Homebased Care Coventry, comments included, "I really enjoy my job, that's why I do it. It's certainly not for the pay." Another told us, "I love my job and working for Homebased Care, I think the care has improved a lot. All the staff are really caring about people, before some staff just couldn't give a toss."

As well as the managers operating an 'open door' policy where staff could call into the office at any time, there was also an 'on call' telephone number they could contact 24/7 to speak with a manager if they needed to. This provided staff with leadership advice whenever they needed it.

Staff said communication from the office worked well and that office staff were helpful and approachable. Staff said they were kept up to date about changes in peoples care and any changes in policies. Staff also said they felt supported by the management team and senior managers, one staff member said, "Senior managers are fantastic, really helpful."

The provider told us the most important asset Homebased Care had was "its workforce and every effort is made to look after them." They had introduced a staff recognition and reward scheme that included 'carer of the month' for each branch. At the end of the year they recognised staff contributions by holding an awards evening, for carer of the year, manager of the year and branch of the year.

The managers undertook regular checks of the quality of the service. When people's daily records were returned to the office, they checked the records matched the care plans and that people's medicines administration records (MARs) were completed in full, to confirm people received their medicines as prescribed. In addition 'spot checks' on staff were undertaken to ensure they worked to the provider's policies and procedures to provide safe care to people.

The provider sent surveys to people and staff to find out their views of the service. The response to the survey sent to people in 2016 had been low and only ten surveys had been returned. We looked at a selection of returned surveys, which showed mainly positive comments about the service, for example "The service is good when regular carer comes." The staff surveys indicated the company treated staff fairly, that communication had improved since the 2015 survey and that staff had opportunity to speak with the managers as often as they needed to.

The provider held Focused Groups with service users twice a year to provide a forum where people could share their views and opinions of the service received. The minutes from the last meeting held 18 April 2017 showed people who attended felt safe with the care staff, thought care staff were respectful and had regular care workers. The compliance manager told us they were planning on increasing the groups to four times a year.

The provider had received a monitoring visit from the local authority commissioning officer, in February 2017 and had recently received the report. The compliance manager said they were completing an action plan to address the shortfalls identified, that included, variation of people's call times, and staff communication issues. We asked the provider to send a copy of their action plan to us.

We found the managers who supported our inspection to be open and transparent during our visit. The office was well organised and all the documentation we requested was made available to us.

In the last 12 months the Coventry branch had achieved the 'Investors in People' bronze award. This is a recognised accreditation for the quality of care and support provided by the service.