Andersen Care Limited

Andersen Care Agency

Inspection report

837 High Road
London
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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

This inspection took place on 3 and 4 May 2016 and was announced. We gave the provider two weeks' notice that we would be visiting their main office to ensure that the registered manager would be available on the day of the inspection.

Andersen Care Agency provides personal care and support to people living in their own homes or within supported living schemes. There were approximately 60 people using the service at the time of the inspection.

The service was last inspected on 3 December 2013 and was meeting all the standards that we looked at.

The service had a registered manager in post at the time of the 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 2008 and associated Regulations about how the service is run.

Each person using the service had a care plan which included information about the person and how they wished to be supported. Health, safety and environmental risk assessments had been completed which highlighted potential risks and how those risks could be mitigated. As part of the pre-service assessment, personal and individual risks were identified but the service did not complete an assessment of those identified risks such as risks associated with choking or pressure sores.
Incident and accident records were kept as part of that person's care plan. The registered manager did not have an overview of all accidents and incidents that had occurred across the service so as to be able to monitor any patterns or trends.

People and relatives that we spoke with were happy with the care that they received. They received regular and consistent staff who were caring and ensured that their privacy and dignity was maintained at all times.

People told us that they felt safe in the presence of the care staff that supported them. Care staff demonstrated a good understanding of safeguarding and what this meant in order to ensure people were protected from abuse. They knew who to report abuse to and were confident that management would take immediate action.

Care plans had been signed either by the person using the service or their relative. People and relatives told us that they were involved in the planning of their care and also confirmed that the service regularly reviewed their care package with them.

People and relatives told us that they were allocated a main carer who supported them on a regular basis with a bank of carers who would cover the calls when the main carer was off on leave or was unable to work due to sickness.

People and relatives told us that they felt staff were adequately trained and had the ability and skills to provide good and effective care. Staff also told us that they received training prior to starting work as well as on-going training as part of their personal development.

The service had recruitment process in place which ensured that only suitable staff were employed.

The service had policies and procedures in relation to the MCA. The registered manager, senior staff members and care staff had a good understanding of the MCA and that they should always presume that people have the capacity to make decisions.

People and relatives told us that they did not have any complaints about the service. They knew who the registered manager was and felt confident to report any concerns or issues they may have. People and relatives were also confident that their concerns and issues would be dealt with promptly.

The registered manager had systems in place to monitor and check the quality of care being provided. This included spot checks, care worker's work place assessments and weekly monitoring of late and missed visits. However, where care worker work place assessments had been completed and staff had been rated poorly in a particular area, there was no record of what action had been taken in order to improve care practises.

People and relatives were asked to complete six monthly quality questionnaires to obtain their feedback on the service that they received and if there were any improvements to be made. People and relatives confirmed that they regularly completed these questionnaires but in addition the care co-ordinators also maintained regular contact with them through the telephone and home visits to ensure that they were happy with the care they were receiving.

The service kept records of people's birthdays and organised parties where the office team and the regular carers would take a cake, balloons and gifts to celebrate the person's birthday.

We have made one recommendation in relation to the registered manager creating an overview of incidents and accidents.

We identified a breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This breach was in relation to assessing risks associated to people's care and support needs. You can see what action we 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?

Requires Improvement

The service was not always safe. Although the service identified people's individual and personal risks, a detailed risk assessment had not been completed that gave staff further detail about the risk and guidance on how to manage and mitigate those risks to ensure people's safety.

Incident and accident records were kept as part of that person's care plan. The registered manager did not have an overview of all accidents and incidents that had occurred across the service so as to be able to monitor any patterns or trends.

People told us they felt safe with the staff that supported them. Staff knew about the different types of abuse and how to respond to any signs of potential abuse.

The service had recruitment processes in place to ensure the safe recruitment of staff.

Staff had received training in medicines management and had also completed competency assessments to assess their knowledge and effectiveness of the training they had received.

Is the service effective?

Good

The service was effective. Staff received training in a variety of areas and this was refreshed on a regular basis. Staff told us they were supported well and received regular supervision.

People's capacity was assessed as part of the pre-service assessment and this was documented within the care plan. Care plans were signed by the people receiving the care or their relatives where a person was unable to sign.

People were supported to maintain their health and access healthcare services where required.

Is the service caring?

Good

The service was caring. People and their relatives told us that they received a good service from care staff who were caring and considerate and maintained their privacy and dignity.

People received care from regular carers who knew the people they supported.

Staff understood that people's diversity was important and that the support they provided to people should be equal and fair and that people's backgrounds should not impact on the care that they received.

Is the service responsive?

Good

The service was responsive. Each person had a care plan that contained information about them and their assessed need. Care plans were reviewed regularly.

People and relatives were involved in the planning of care and were also part of the review process when this took place.

People and relatives told us that they did not have any complaints about the service they received. They felt confident and knew who to contact and that if they did have any issues that these would be acted upon and resolved.

Is the service well-led?

Good

The service was well-led. People and their relatives knew the registered manager and the senior management team. Relatives told us that the registered manager visited them to introduce themselves when a new care package was commissioned.

The service had systems and processes in place for monitoring the quality of care. Regular spot checks and work place assessments were carried out as well as monitoring of late visits and missed calls.

People and their relatives told us that the service maintained regular contact with them to obtain their feedback on the quality of care that they were received. They also confirmed that they completed regular quality questionnaires that were sent by the service.

Andersen Care Agency

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 3 and 4 May 2016 and was announced. We gave the provider two weeks' notice that we would be visiting their main office to ensure that the registered manager would be available on the day of the inspection. On 3 May 2016 we visited the registered office and looked at their records, policies and procedures. On 4 May 2016, with prior consent, we undertook visits to people's own homes to speak with them about the service that they received. As part of this visit we also looked at records that were held in people's own homes. In addition to these visits we spoke with people and staff by telephone to obtain their feedback about the service.

The inspection was undertaken by one inspector. Before the inspection we looked at the information we had about the service. We reviewed the completed PIR and previous inspection reports before the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also reviewed other information we had about the provider, including notifications of any safeguarding or other incidents affecting the safety and wellbeing of people and obtained feedback from local authority commissioning officers.

During the inspection we spoke with the registered manager, two care co-ordinators, the nurse assessor and four care staff. On the second day of the inspection we visited and spoke with three people who used the service, three relatives and a visiting district nurse. Telephone calls were also made to a further four relatives and two care staff.

We looked at nine people's support plans and other documents relating to their care including risk assessments. We also looked at four care records that were kept at people's homes.

We looked at other records held by the agency including seven care staff files, meeting minutes as well as health and safety documents and quality audits and surveys. After the inspection we requested a number of

documents from the provider including the staff supervision records and team meeting minutes.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that they felt safe with the care and support that they received from the service. One person told us, "When they come at night, I sleep well, I feel safe." Another person told us, "Oh, I do feel safe with them." Relatives told us, "I trust them to get on with their work" and "My relative feels safe with the carer."

Each person receiving a service had a care plan in place, which outlined people's assessed needs and requirements. As part of the care planning process, the service completed a health and safety risk assessment checklist and a manual handling risk assessment. These covered areas such as falls, slips and trips, pets, use of chemicals, fire, electrical and gas safety. The service also identified people's individual and personal risks such as risks associated with choking, pressure sores, malnutrition, aggression and the risk of someone getting lost when out in the community. However, the service did not assess these risks and did not provide further detail to care staff on these identified risks and guidance on how to mitigate/reduce risk to ensure people's safety.

The service had a risk assessment policy in place which stated that, "The company's risk assessment must be completed and any identified risks addressed, if possible to eliminate them or reduce the risk as much as possible." The provider was failing in following their own internal policy.

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

We spoke with the registered manager and the nurse assessor about risk assessments who agreed that this was an area that had not been considered and explained that to date they had felt that the information contained within the care plan provided staff with adequate information to protect people. On the second day of the inspection, the service presented a new risk assessment form, which they planned to implement immediately, to assess people's individual and personal risks associated with their care and support needs. The form included details of the assessed risks and the actions care staff were to take to mitigate those risks.

Accidents and incidents were recorded on an accident and incident form. All accidents and incidents were reported to the office and a record was made which outlined the date of the incident, details of the incident and what action was taken. These records were kept in people's care plans. For one person we noted that three consecutive incidents had taken place. The registered manager was able to show us an audit trail of the action that they had taken, which included email correspondence with the social worker and minutes of meetings held with the family to discuss the issues and concerns raised as a result of the recorded incidents. However, as incident and accident records were kept as part of that person's care plan, the registered manager did not have an overview of all accidents and incidents that had occurred across the service so as to be able to monitor any patterns or trends. This would ensure that through identifying any potential trends or patterns people were kept safe and any such risks were reduced.

The service had policies and procedures in place for the protection of people from abuse. We saw two policies that were available for staff to refer to. One was a 'Safeguarding of Vulnerable Adults Policy' and the other was a 'Client Abuse Policy.' Both policies were detailed and provided information about the different types of abuse, definitions and indicators of abuse and what actions to take if abuse was suspected. The policy outlined which people were to be informed including the local authority and the Care Quality Commission (CQC) but no contact details had been noted within the policy. We highlighted this to the registered manager who told us that they would update the policy to include the contact details of the external bodies mentioned in the policy.

Staff we spoke with knew what safeguarding vulnerable adults meant and what constitutes abuse and the actions that they must take if they suspected abuse was taking place. Care staff told us when asked about their awareness of safeguarding, "Safeguarding is about keeping the client safe. If we suspect abuse we have to report to the office and the office always react" and "We have to report anything to the office and they have to take action. If they don't take action we can contact the local safeguarding team."

Staff we spoke with understood the term 'whistleblowing' and whom this must be reported to. Staff were aware that they would need to report concerns, even if this involved a colleague with whom they worked with. Staff were very confident that the management would take immediate action if they had concerns but also knew they could contact the local authority or the CQC. One care staff member told us, "I will support and protect my client."

The agency employed approximately 40 care staff members. No concerns were noted in relation to staff shortage. We looked at recruitment records of nine care staff. We found that the service had systems in place to ensure that staff were safe and suitable to work with people. Recruitment files contained the necessary documentation including references, criminal record checks and information about the experience and skills of the individual. However, one file we looked at only had one reference available and on a second file we noted that the referee's name had not been completed on the form. We highlighted this to the registered manager who assured us that this would be rectified immediately.

We saw that the agency carried out checks to make sure that staff were allowed to work in the UK. The registered manager held an employee data overview with had information about the dates of when a visa was approved and the date of when it was due to expire so that the provider could follow up with the staff member to ensure that they continued to work legally in this country. The registered manager told us that where a staff member was unable to evidence their legality to work in this country they would be refrained from work until documentary evidence was provided.

The provider had an in-house rota system which they managed through a computer spreadsheet. Care co-ordinators would be responsible for setting the rota on a weekly basis, taking into account any changes requested by people and their relatives and all staff annual leave requests. The rota was a live document which also accounted for any last minute changes and staff sickness or absences. Rotas were sent to staff on a weekly basis. We noted that staff had been allocated travel time between shifts, which depended on whether they drove a car or if they were using public transport. The registered manager and care co-ordinator explained to us the system in place for allocating care staff to a care package, which included ensuring each person had a team of regular carers and that carers were allocated to care packages in the same areas to reduce travel time and the risk of late or missed calls. The registered manager also told us that they had a system in place where care staff were given an enhanced rate of pay to cover any sickness or last minute cancellations of shifts. This ensured that there was always cover available so that people always received the allocated support and care. The service did not have any recorded missed visits.

We recommend that the service considers developing an overview of all accidents and incidents in order to be able to note any trends or patterns so that improvements in care provision and learning from accidents and incidents can take place.

Good

Is the service effective?

Our findings

People who used the service and relatives told us that they felt care staff had the knowledge and skills to provide effective and good care. Relatives, when asked if they felt staff were adequately trained, told us, "Yes, they are trained" and "They are on point, top marks for communication and documentation." Another relative told us, "Yes, they are trained to support my relative, they don't have to be specially skilled or trained."

Prior to commencing employment with the agency, care staff were required to attend an induction programme which covered training in mandatory topics such as the role of a care worker, equality and diversity and safeguarding. Training records that we looked at confirmed that all staff had undergone this induction training. We also saw that as part of the training, care staff undertook competency assessments especially in relation to medicine management, which assessed their knowledge post completing the medicine management course.

The provider was due to implement the care certificate for all staff newly employed and as good practice planned to deliver the programme to all existing staff as well. The care certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support and is covered as part of induction training. The registered manager and three other senior staff members had recently undertaken training so that they would be able to assess care staff for their competencies as part of the care certificate training. This training was planned to be delivered over the forthcoming months.

A training matrix was provided which outlined all the topics staff had undertaken training in. In addition to the mandatory topics, training was also provided in areas such as challenging behaviour, dementia, palliative care, mental capacity and hand hygiene. The training matrix, however, did not provide dates confirming when the training had taken place or when it was due to be refreshed. We highlighted this to the registered manager who told us that all staff training was refreshed on an annual basis. Care staff that we spoke with confirmed that they received regular training and that if they needed any additional training they would only have to ask. A care staff member told us, "When I need training all I have to is ask" and "I get lots of training."

Care staff told us that they felt well supported by the care co-ordinators and registered manager. When asked if they received regular supervision three staff members were unsure by what this meant but did tell us that they met regularly with the care co-ordinators and that someone was always available to deal with any concerns or day to day issues that they may have. Care staff told us, "[Name of care co-ordinator] you can call them anytime and they are very supportive. They are always available to talk to. Every so often we meet and some of these meetings are documented", "I have regular supervision and every Monday I see my manager. With a particular client, anything I need I get help and advice." When asked about receiving regular supervision one care staff told us, "It depends, when issues come up. Sometimes I do sign to confirm I have received supervision."

During the inspection we asked the registered manager to show us supervision records for staff members over the last year. The registered manager only had records of supervisions that had been completed over the last five months as all previous records had been archived in a storage unit away from the office due to lack of space within the office. We asked the registered manager to send us copies of supervisions for four staff members that covered the previous year. Records that were sent to us showed that care staff were receiving regular supervision in accordance to the provider's supervision policy, which stipulated that a supervision should be held once every quarter. Appraisals had been completed for care staff and we saw records for ten care staff confirming this. However, we were unable to evidence whether staff had received appraisals in previous years, as records were not held at the office and immediate access to these documents on the day of the inspection was not possible.

In addition to supervisions, care co-ordinators and senior field supervisors carried out work place assessments for all care staff. This included observing care staff whilst they were supporting people with their care and rating them in areas such as communication, delivery of person centred care and whether they arrived on time for their call. However, where staff were rated poorly in any particular area, there was no record of what action had been taken in order to improve care practices. For example, whether supervisions had been completed to address poor practises or if a care staff had received refresher training. This was highlighted to the registered manager and the field supervisors to consider as part of improving their own practises.

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.

We checked whether the service was working within the principles of the MCA. The service had policies and procedures in relation to the MCA. The registered manager, senior staff members and care staff had a good understanding of the MCA and that they should always presume that people have the capacity to make decisions. Staff explained that in situations where people were unable to make decisions they would report this to the care co-ordinators who would meet with family, friends or advocates in order to explore the options available so that decisions could be made, which were in the person's best interest. One care staff member told us, "Where someone lacked capacity and for example refuses personal care I would report this to the office. It's about giving people choice and making them aware of the choices that they have. Ultimately if they can't make decisions we can speak to office and discuss with family members." Another care staff member told us, "If people can't make a decision always try and find a solution. Always remind and prompt people, always explaining what to do and the reasons behind why we are doing things. After doing these things the person I care for always agrees."

People receiving care and their relatives also confirmed that care staff always asked permission and obtained consent before providing any care and support. One relative told us, "They try to talk and ask permission." Another relative told us, "We as a family are involved."

Pre-service assessments and care plan documents explored people's capacity and where people lacked capacity this was specified within the care plan including detail of any particular areas in which people required support and for decisions to be made in their best interest. Consent to care was obtained and care plans had been signed either by the person receiving the care and where they were unable to sign, care plans were signed by a family member.

The service provided care to people within their own home. Care staff were not involved in menu planning for people and were not always involved in monitoring people's nutrition and hydration as they would only be present at the person's home at certain times throughout the day for a specific time period. The service did support people with preparing basic meals or heating up pre-ordered ready meals. However, for one person who was at risk of malnutrition and dehydration and where 24 hour support was being provided, care staff, in conjunction with the district nurses, had systems in place to monitor the person's food and fluid intake to ensure the person's nutritional and hydration needs were being met.

Care plans contained information about people's dietary requirements. This included specific information about any cultural or religious requirements or where people had been assessed by the speech and language therapist and required a specific type of meal or where thickening agents were required because the person was at high risk of choking. Care plans had very little information about people's likes and dislikes. However, on one care plan we looked at, it was noted that a person liked having an alcoholic beverage with their meal.

Where a speech and language therapist had been involved, we noted that the nurse assessor worked closely with the therapist to ensure people were supported appropriately with any special requirements. One person required a thickening agent to be added to liquids to reduce the risk of choking. We saw that the speech and language therapist had provided guidance and instruction posters for staff on how to administer the thickening agent, how many scoops of the agent were to be mixed into a set amount of liquid and how the person was to be supported safely when having their meal or a drink. This was displayed at the person's home.

Care plans provided information about people's current health, medical needs and the medicines that they had been prescribed. Staff that we spoke with knew the people they cared for and were well aware of their health and medical needs. Care staff always recorded and reported any concerns or changes in people's health to the care co-ordinators or the registered manager. Staff also supported people to make hospital appointments where required and the service provided an escort service to these appointments. Care staff knew who to contact if there were any concerns about people's medical health including emergency contacts. The agency also worked very closely with district nurses and other medical professionals to ensure people received the appropriate care and support.

The registered manager told us that where people had been admitted to hospital and were due for discharge, the nurse assessor would always try and assess the person before discharge so that a review of their care needs and support was undertaken to ensure that the agency provided the appropriate level of care once the person arrived back home.

Good

Is the service caring?

Our findings

People told us that the carers that supported them were caring and treated them with dignity and respect. Comments that people made included the following, "Staff are caring", "Excellent", "I get the best, I am in good hands", "They are first class, they are wonderful" and "they are very helpful, friendly and caring. My carer is beautiful."
Relatives told us, "Yes, I am happy with the care", "We have regular carers that we love", "The carers are respectful and caring" and "The carers have a laugh with my relative, they are very good."

On the second day of the inspection we visited people in their own homes. For one person whom we visited, the carer had already arrived and was supporting the person whilst we were waiting outside. Whilst we were waiting we could hear meaningful conversation about the weather and how the person was as well as humour between the person and care staff.

The service kept records of people's birthdays and organised parties where the office team and the regular carers would take a cake, balloons and gifts to celebrate the person's birthday. Where relatives were present they would be involved in the celebrations. With consent, videos and pictures of these celebrations were taken and where relatives lived far or abroad, these photos and videos were sent to them so that they could that feel they were part of the celebration.

People's care plans contained information about the person which included information on their religion, the languages they spoke, any relevant health details and the roles and responsibilities of others including family, friends or other agencies. The plan also outlined the agreed outcomes of the care to be provided and the agreed plan of care. This included details of the tasks to be undertaken, the timing of the calls and the names of the care staff that had been allocated. However, the plans did not always list peoples likes, dislikes and preferences and lacked the element of being person centred. We spoke to the registered manager about this who agreed to look into this in order to improve the care plans so that they were more person centred and less task focused.

People and relatives confirmed that they had a regular team of care staff that supported them on a daily basis. Staff also confirmed that they worked with the same people and had got to know them really well. One care staff told us, "Because we get to know the person you get to know what their likes and dislikes are."

People and relatives told us that they had been involved with their care planning process and had also been involved in the reviewing of their care when necessary. A relative told us, "We as a family feel involved, they [the service] takes on board our suggestion and oblige" and another relative commented, "I feel involved." People told us that staff always respected their privacy and dignity and always gained their consent prior to carrying out any care tasks.

People confirmed they were offered choice in how they received their care. Staff demonstrated a good understanding of how to promote people's independence by involving them and giving them choice and control over the care that they received. Care staff gave us different examples of how they promoted

independence and gave people choice. One care staff member told us, "I ask people how they want things to be done, they are human beings and they have rights" and another care staff member commented, "I ask them [people] what they want and give them a couple of options. When supporting them with care I ask them 'do you mind if I help you wash or would you like to do it yourself'."

We saw records confirming that staff received equality and diversity training as part of their induction. The registered manager confirmed that this also included a session on privacy and dignity. Care staff that we spoke with had an awareness of how people should be supported equally regardless of their gender, race, sexual orientation or religion. One care staff member when asked about equality and diversity in relation to religion told us, "I talk to them [people] and get to know their religion. If they follow a different religion I find out about how to support them. I ask them if there is anything I should or shouldn't do or be aware of so that I don't offend them." One staff member when asked about supporting people with a different sexual orientation told us, "I help them, they are also human and would not treat them differently."

Good

Is the service responsive?

Our findings

People and relatives told us that the communication between care staff, the people they support, relatives and the office was very good. One relative told us, "If there are any concerns with my relative regarding their health or the care they receive, the care staff always go and inform the office and the office calls me straight away" and another relative commented, "I can contact the team anytime 24 hours a day and I know things will get sorted."

People and relatives confirmed that they had a team of regular carers which included one main carer and two or three named carers who could cover the calls when the main carer was not available. People and relatives also confirmed that care staff arrived on time and stayed for the full duration of the call. Where any changes were to be made, the office always communicated with people and relatives to inform them of the changes.

The service carried out an assessment of needs prior to any care and support being provided to ascertain whether the service could meet the person's needs. The registered manager told us that they only took on care packages where they were confident that they could adequately meet the person's needs. Care plans that we looked at confirmed that regular reviews were taking place for people receiving care and support. However, the service needed to ensure that copies of updated and reviewed care plans were placed within the file held at people's own homes, as the homes that we visited did not have a copy of the most recent and updated version of the care plan.

Daily recording books were used to record the date of the call, the time the care staff arrived and left, details of the care plan tasks that were delivered and any other essential information. The records that we checked when visiting people at their own homes were complete and contained detailed information about the care and support that staff had provided. One care staff whom we spoke to about recording and reporting told us, "This is me, I have to write down the detail to let the next person know what is happening."

People and relatives that we spoke with told us that they did not have any complaints to make. They also told us that they knew who to contact and felt confident that if they did have any concerns or issues, the office would deal with these immediately. One person receiving care told us, "It hadn't occurred to me to wander as long as things turnover, there has never been a need to complain." One relative told us, "I know the agency and feel confident in complaining" and another relative commented, "I haven't had any reason to call the office and complain.

The service had a complaints policy in place which outlined how the service would deal with any complaints that were received and the timeframes that this would be done in. The policy also included contact details of the CQC and the local authority, to which a person may complain if required. Complaints that we looked included details of the complaint and the actions that the service had taken to resolve the complaint. We also saw a number of very positive compliments that had been sent in to the agency.

Good

Is the service well-led?

Our findings

People and relatives knew who the registered manager was and were particularly complimentary of the care co-ordinators, care staff and the overall way in which the service was delivered and managed. People and relatives told us that when they first started receiving a service, the registered manager, visited them to introduce themselves and to give them their direct contact details so that if they had any concerns or issues they knew who to contact directly.

On the second day of the inspection, when we visited people at their homes, we observed that the registered manager and the care co-ordinator knew the people they supported well and people and relatives also responded to them in a positive manner. One relative told us, "I had a visit from [name of registered manager] to see how things were and if there were any problems to get back to the office."

Staff feedback about the support they received from the registered manager, care co-ordinators and field supervisors was also very positive. A care staff told us, "They [the office] are supportive, they help us with issues. We have clients who are difficult but the office guides us on what to do" and another care staff commented, "When I have problems or I need something I can call [name of care co-ordinator]."

We also noted that the registered manager, nursing assessor and care co-ordinators maintained effective working relationships with district nurses, social workers and a variety of other health professionals to ensure that people received a co-ordinated and holistic approach to the provision of care and support. A district nurse, who we met at one person's house told us, "The carers are very good and I meet the same carers every time I visit."

Care staff told us that the office regularly communicated with them by telephone, text messaging and emails about any day to day issues or updates around the provision of care. The service also held six monthly town hall meetings for staff members to discuss general topics and issues in relation to the provision of care and support. The meeting would be scheduled for the whole day where different time slots were set, so that maximum attendance by care staff was possible. Agenda items included the services vision, lateness, effective communication and recording and client service delivery. Minutes of these meetings were produced and sent to any staff member that had been unable to attend.

The registered managers and all senior staff members also held weekly meetings at the beginning of the week. These meetings were recorded and discussed the handover from the previous week and weekend, issues or concerns that had arisen in the previous week, reviews that were due, care packages where concerns had been identified and a follow up on any complaints that had been received.

The registered manager had systems and processes in place to check and monitor the provision and delivery of personal care and support. These included systems to monitor when a person's care and support package was due for review, a record and overview of late and missed visits, work place assessments and unannounced spot check visits. We looked at the overview and monitoring of late and missed visits. The service had no recorded missed visits, but had identified a pattern for recorded late calls which seemed to

be at the weekend especially when a football match was being played in the local area. Action taken was recorded which included informing the relatives that the carer was going to be late.

The service carried out quarterly quality assurance surveys. We saw six questionnaires that had been completed and were positive in relation to the feedback that had been provided. Relatives also confirmed that they had been asked to complete quality assurance questionnaires. The registered manager explained to us that although these questionnaires were completed on a quarterly basis, there were occasions where if issues or concerns had been identified then a questionnaire would be completed on a more regular basis. Questionnaires were not only sent out by post but were also completed over the telephone or through a one to one visit.

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 12 HSCA RA Regulations 2014 Safe care and treatment Regulation 12(1)(2)(a)(b) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Safe care and treatment People using the service were at risk because the service did not assess and mitigate individual risks identified as part of the care and support plan.