Dale Care Limited

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Inspection report

13 Hope Street
Crook
County Durham
DL15 9HS

Tel: 01388768271
Website: www.dalecare.co.uk

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Ratings

Overall rating for this service	Good

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?	Good

Summary of findings

Overall summary

The inspection took place on 19, 20, 21 and 22 June 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The service was last inspected by CQC in May 2016, at which time the service was in breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Health and Social Care Act 2008 (Registration) Regulations 2014. During that inspection we found the provider did not ensure the proper and safe management of medicines. Additionally they had not notified CQC of alleged instances of abuse by way of medicines errors. The provider had failed to ensure there was an accurate, complete and contemporaneous record in respect of each service user. There were insufficient numbers of staff deployed to meet people's needs through the implementation of an effective rota system. We also found that not all staff had received the appropriate training.

At this inspection we found improvements had been made and the provider had completed each of the improvement actions necessary. Robust systems were in place to investigate and analyse medicines errors, as well as systems to learn from these errors. Records had been improved and of the records we reviewed we found they were accurate and up to date. Training of staff had been addressed and improvements had been made. In addition to the above we also found that CQC had been notified of all relevant events as required.

Dale Care is a domiciliary care provider based in Crook providing personal care to people in their own homes in County Durham, Gateshead, Newcastle and surrounding areas. There were approximately 1,300 people using the service at the time of our inspection.

The service had a registered manager in place. 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.

We found medicines administration was supported by robust medicines and disciplinary policies. Where mistakes were made, appropriate support and investigations took place, as well as notifications to the appropriate agencies.

People who used the service felt safe and relatives had confidence in the ability of staff to keep people safe. Staff had received safeguarding training in safeguarding and understood their responsibilities. There was an out-of-hours phone line in case of unforeseen circumstances and people did not report they had experienced any missed calls recently.

Risks were assessed by an area supervisor when someone first started using the service, and reviewed

thereafter. Pre-employment checks, including Disclosure and Barring Service checks, were in place.

There were sufficient numbers of staff on duty to meet the needs of people who used the service, although the planning of individual staff rotas still required improvement to ensure people received a better continuity of care.

New staff received a seven-day induction, as well as shadowing opportunities. The provider agreed shadowing practices could be further improved but we found mandatory training covered a range of core topics, such as: safeguarding, infection control, dementia awareness, first aid and nutrition. The registered manager and training manager ensured staff completed refresher training.

Staff liaised regularly with external healthcare professionals and ensured their advice was incorporated into care planning.

Staff were supported through annual appraisals and a number of supervisions throughout the year – the timings of these were not always consistent and the provider had recently introduced a new supervision format for staff. Initial feedback regarding this was positive.

People who used the service and relatives consistently told us staff were caring, patient and upheld people's dignity. People confirmed staff encouraged them to retain their independence on a day-to-day basis.

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

People told us they were encouraged to contribute to their own care planning and review, and felt partners in the process.

People who used the service and external professionals told us staff were accommodating to people's changing needs and preferences.

People who used the service knew how to complain, and who to. This information was shared with people in a welcome pack. Complaints were thoroughly investigated and responses given, whilst a quality assurance and complaints team had been set up to help the provider learn from mistakes.

The registered manager, regional director and care staff were described in positive terms by people who used the service and relatives. We found leadership of the service to be an effective balance of experience and trialling new ideas. Auditing and quality assurance systems were in place to enable the provider to identify trends.

The culture of the service was in line with the goals of the statement of purpose, meaning people who used the service were supported to maintain their independence from care staff who demonstrated a good understanding of people's needs and individualities.

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.

Additional medicines administration training was planned, whilst additional observations had been put in place to monitor staff competencies.

Staff received regular safeguarding training and had raised concerns about people where appropriate. The provider responded to concerns and proactively involved other agencies to keep people safe.

Pre-employment checks of staff ensured the risk of employing someone unsuitable to work with vulnerable people was reduced.

Is the service effective?

Requires Improvement

The service was not always effective.

People who used the service did not always receive the support they needed on time, because the rota-planning system was not fully effective.

New staff received a range of mandatory training and shadowing support prior to supporting people who used the service.

Staff received regular appraisals, whilst the supervision process had recently been reviewed to include more practice-based observations.

Is the service caring?

Good

The service remained good.

Is the service responsive?

Good

The service remained good.

Is the service well-led?

Good

The service was well-led.

The registered provider and regional director ensured appropriate notifications were sent to CQC and that external agencies were updated when major incidents occurred.

Auditing and quality assurance processes were in place, including a dedicated team to follow up on complaints and improving service provision.

People who used the service and their relatives were generally complimentary about the leadership of the service, as were staff.

Dale Care Limited

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.

The inspection took place on 19, 20, 21 and 22 June 2017 and was announced. This meant we gave the provider 48 hours' notice of our intended visit to ensure someone would be available in the office to meet us.

The inspection team consisted of two adult social care inspectors and eight experts by experience. An expert-by-experience is a person who has personal experience of using or caring for someone who used this type of care service. The experts in this case had experience in caring for older people, people living with dementia, people with physical disabilities and people with mental health needs.

Before our inspection we reviewed all the information we held about the service. We examined the previous action plan sent to CQC by the provider and notifications received by the CQC. Notifications are changes, events or incidents that the provider is legally obliged to send us within the required timescales. We spoke with four staff from local authority commissioning and safeguarding teams. We spoke with the local Healthwatch. Healthwatch are a consumer group who champion the rights of people using healthcare services. We also contacted two health and social care professionals.

We asked the provider to complete a Provider Information Return (PIR). This is a document wherein the provider is required to give some key information about the service, what the service does well, the challenges it faces and any improvements they plan to make. This document had been completed and we used this information to inform our inspection.

During the inspection we reviewed ten people's care information, looked at a range of staff records, policies, procedures, auditing, rota information, survey information and IT systems. We spoke with 75 people who used the service and 24 relatives. We visited three people in their homes. We also spoke with 15 members of staff: the regional director, the registered manager, the operations manager, the leader of the triage team, a

member of the complaints/QA team, two care co-ordinators and eight care staff.

Good

Is the service safe?

Our findings

At the previous CQC inspection of May 2016 we identified concerns that the provider had not managed medicines in a safe manner, nor had they notified CQC of relevant medicines errors. During this inspection we found the provider had made improvements in both regards. We saw any errors were consistently documented via new workflow documents, which ensured staff had to decide whether the incident should be referred to CQC (or other bodies). We found the system to be working well and, where errors had occurred, we saw action had been taken, ranging from supportive measures such as re-training to disciplinary action where there were ongoing concerns about a member of staff. We saw the number and consistency of direct observations of staff whilst administering medicine had increased and that additional medicines training had been planned, in addition to the mandatory medicines training provided. This demonstrated the provider had taken steps to ensure they complied with the regulations and meant people who used the service were at less risk of the unsafe administration of medicines.

When we reviewed people's medication administration records (MARs) we found these had been completed accurately, whilst medicines audits were in place. We saw these identified errors and areas for practice improvement and that the registered manager analysed the outcomes of these audits to identify whether there were common problems occurring.

People who used the service told us, "They do my medication properly – they give me all my tablets and are spot on. They always write down what they give me." Another said, "They do my medicines now. That didn't use to happen, they weren't allowed to, but they are trained now so they do it and it's alright," "They sort out my tablets and put cream on my legs and feet. They wash their hands before they give the tablets to me and make sure I've managed to take them with a drink of water and then write everything down." One person stated it was a running joke between them and their regular carer that they would ask them to confirm their identity before administering the medicine, but the person using the service appreciated this balance of adhering to good practice and conducting themselves in a friendly manner. Relatives we spoke with similarly raised no concerns about the administration of medicines. When we reviewed people's care plans on the provider's IT system and in hard copy documentation in people's home we found the administration of medicines to be effective and safe. Where we identified areas for improvement, the manager and regional director were receptive to this. We noted the provider's medicines policy had been updated in line with the latest guidance issued by the National Institute for Health and Clinical Excellence (NICE).

Commissioning professionals we spoke with agreed they had seen a decrease in the number of medicines errors over recent months and that the new systems of observations had had a positive impact. This demonstrated the provider had addressed areas of non-compliance since the last CQC inspection in May 2016.

External professionals also agreed they had more generally seen a decrease in serious safeguarding issues occurring and that, where there were concerns, the provider was more proactive in raising these and alerting the appropriate agencies. We saw incidents and accidents were consistently recorded and these were also

regularly analysed by the manager.

Safeguarding training was delivered as part of the provider's induction and staff received refresher training on this topic. When we spoke with a range of staff they were clear about their safeguarding responsibilities and how they could raise concerns.

People who used the service and their relatives told us they felt safe in the presence of staff, and that they were trustworthy and sufficiently skilled to keep them safe. One person said, "I feel very safe with them," whilst a relative told us, "My relative is very safe with the carers. I have absolutely no worries."

People cited staff following good infection control practices as an example. One person told us, "They always use gloves and aprons," and another, "They clean up nicely." We saw the provider delivered infection control training during the induction, had ample personal protective equipment (PPE) available on site and had introduced and infection control champion. Whilst this had yet to have an impact on staff meetings or practice improvements, it demonstrated the provider valued the importance of infection control and the need to ensure staff were kept abreast of good practice and future developments in this area.

We saw a range of pre-employment checks were in place, such as Disclosure and Barring Service (DBS) checks. The DBS restrict people from working with vulnerable groups where they may present a risk and also provide employers with criminal history information. It also stores and shares criminal history information for when relevant employers request this. Other pre-employment checks included gathering references from previous employers and exploring any gaps in employment. This meant staff were subject to suitability checks prior to working with potentially vulnerable individuals.

There was an out of hours team who took calls from staff and people who used the service should they encounter unexpected problems outside of office hours. People who used the service confirmed they knew who to contact in an emergency and we saw this information was made available to people in the welcome packs they were given.

We saw risk assessments were completed during the first visit by an area supervisor, highlighting any obvious areas of risk, such as trip hazards and electrical risks. We also saw risk assessments specific to people's individual conditions and needs were in place and these were reviewed regularly, or when a change occurred. For example, one person was at risk of suffering a seizure. We saw there were instructions in this person's care plan telling staff what they needed to do if they were concerned about a change in the person's mannerisms or behaviours and what they needed to do should they be concerned a seizure was imminent. We saw evidence of advice being sought from external professionals about the specific risks people faced, and this information being incorporated into care files.

Staff we spoke with demonstrated a good understanding of the risks people faced and how they helped people minimise these risks. We also noted these risk assessments were under review in terms of the person-centred nature of instructions to staff. We saw an improvement in the more recently reviewed risk assessments when compared to the older ones, in that they contained significantly more detail about how the person wanted to be kept safe, in their own terminology.

Care co-ordinator staff monitored the care visits staff were due to visit and contacted staff members who had not logged into a given call to ensure that people who used the service, and staff, were safe. We found staffing levels to be sufficient to keep people who used the service safe, although there was a consensus of opinion from a range of people that the planning and timing of care calls could be improved. This is discussed further in the Effective key question.

The provider had lone worker training and a suitable policy in place, whilst staff received a personal attack alarm in order to protect them. No staff we spoke with raised concerns about how they were supported as lone workers.

Requires Improvement

Is the service effective?

Our findings

At the previous CQC inspection of May 2016 we identified concerns that the provider had not ensured all staff were appropriately trained to meet the needs of people who used the service. At this inspection we saw improvements had been made and staff had the relevant training to help meet people's needs. We saw the induction training included sections on dementia awareness, safeguarding, infection control, health and safety, moving and handling, fire safety, nutrition, diabetes awareness and pressure sore awareness. The training was delivered over a seven-day induction period (recently extended from five days) and feedback from staff was positive regarding their preparedness. We saw the training modules incorporated best practice from external sources, such as the Alzheimer's Society.

When we asked what was the best thing about working for the provider one staff member said, "The training, definitely." A significant majority of people who used the service and their relatives were in agreement about the capabilities of staff who supported them. They stated, for example, "I have a hoist to get me out of bed and they are well trained in using it – they know what to do," "They understand my needs very well and know what they're doing," and, "I have a lot of equipment but they are very good and professional."

Staff training needs were regularly monitored by the registered manager and the training manager, meaning people received care and support from staff who benefitted from well-planned training provision. When we spoke with staff they were able to describe the training they had received and how it was relevant to their care roles. We also found examples of staff being supported and encouraged to pursue vocational qualifications to further their careers.

The only area where people who used the service and their relatives felt staff knowledge could be an issue was when they received a care visit from a new member of staff. Some staff we spoke with also agreed that getting to know a new person's needs at short notice was sometimes difficult (for example, when they were asked to cover a call at short notice). We saw the induction for new staff included shadowing more experienced members of staff. Whilst all staff we spoke with agreed this happened there was a consensus that shadowing could be more beneficial for staff and for people who used the service. For example, one recent starter confirmed they had shadowed the same member of staff over a number of days. They, and another more experienced member of staff, felt new staff should shadow a range of staff with different skills and mannerisms, to ensure they got a more comprehensive grounding in how to interact with people who used the service. Likewise, care co-ordinators did not routinely shadow care staff, although one care co-ordinator we spoke with who had shadowed care staff confirmed this gave them a greater appreciation of the pressures on care staff when they were organising rotas. The provider stated they planned to provide more shadowing opportunities in the coming year and their aspiration was for all staff to shadow care staff, at least once per year.

With regard to the planning of care visits, we identified concerns at the previous inspection of May 2016 that these were not always well organised, meaning people who used the service experienced delays to calls or late changes to the carer they were scheduled to receive a visit from, or experienced a missed call

altogether. We found the provider had trialled or was trialling a number of ways to improve in this area, such as additional recruitment and an electronic call monitoring system in the Gateshead area. The regional director told us this would be rolled out in all areas if successful, although we saw it had not as yet been implemented effectively, with staff adhering to the system only 60% of the time according to recent figures. Questionnaires returned to CQC demonstrated that the consistency of care visits, both in terms of carers arriving on time and in terms receiving care from a range of different staff, still needed improvement. 43% of people who used the service stated their carer did not always arrive on time, whilst 54% of staff disagreed with the statement that they were able to arrive on time and stay for the scheduled duration of a care visit. When we spoke with people who used the service the majority were happy with their care visit arrangements and, whilst some concerns were raised about the regularity of short-notice changes and delays, there was a consensus that the provider had improved in this area and that missed visits were not a recurrent problem. We reviewed the rota planning system and saw no travel time was built in between care calls. Care staff we spoke with confirmed, "I can get between calls okay because the care co-ordinator puts them close together." Another said, "Sometimes I'm pushed but generally it's okay." We spoke with eight care staff and none voiced significant concerns about the rota planning, although we found there was scope to improve it, particularly with regard to planning in travel time.

The majority of staff we spoke with felt supported in their role, whether through peer support or support from their care co-ordinator. Staff told us they had annual appraisal meetings and intermittent supervision meetings. We saw the provider had put in place a new framework to standardise when care workers would receive supervision support and the kind of support involved. For example, the framework ensured each care worker received a balance of formal discussions with a manager but also observational supervisions whilst completing the care visits. Staff we spoke with who had experienced this revised means of supervision were positive about it and we saw the provider had reviewed the process two months after its implementation, with positive feedback received.

External professionals we spoke with agreed they felt staff had been given the necessary training and, where there were deficiencies with a particular member of staff in terms of their knowledge/practice, they agreed the provider took action in these cases.

In the care files we reviewed we saw people had consented to the care planned. When we spoke with people they confirmed this to be the case. One person said, "They never do anything without asking me if it's alright even though they do the same things most days." Others confirmed that staff asked for their consent when performing individual aspects of care, such as administering medicines or helping someone with aspects of personal care.

We reviewed a sample of daily notes and found them to be sufficiently detailed regarding the tasks the carer had undertaken, such that other professionals could use the information to refer to if needed. Communication between members of staff was good, with clear accountabilities set out for care staff and co-ordinator staff alike.

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. We checked whether the service was working within the principles of the MCA. Staff had received training in the MCA and when we spoke with them demonstrated an understanding of the importance of presuming capacity.

With regard to nutrition, we saw each care file had a specific nutrition section and, when we asked people about this aspect of care, they provided positive feedback about staff. One person said, "They put a pie in the oven, some sweet potato chips and peas for lunch, which is nice," whilst another confirmed, "They do help me with meals and I choose what I want."

Good

Is the service caring?

Our findings

People who used the service and their relatives gave consistently positive feedback about the caring attitudes of staff. People who used the service told us, "They are very polite and lovely – we get on very well," "They are always happy and cheery – it makes my day," and, "They're not carers; they're bloody angels." Relatives we spoke with were, for the significant majority, extremely positive about the relationships staff had formed with their relatives within the context of supporting them, stating, for example, "They have been coming for about a year and we can say they've been brilliant – we like them a lot," and "The carers really go the extra mile."

Likewise, in questionnaires returned to CQC, 100% of people who used the service agreed that care staff were, "Caring and kind," and that they were treated with dignity and respect. We asked people about whether they felt care staff were able to achieve a balance between completing the tasks they needed to and still treating them with patience. Whilst a small number of people felt staff were sometimes rushed and were overly focussed on tasks rather than them, a significant majority of people provided extremely positive feedback, for example, "They speak to me as a person," and, "I'm treated well and they do everything they should. They natter to me as we go."

This focus on the individual also demonstrated that care staff had regard to people's dignity. One person told us, "They chat to me whilst they are helping me – it makes such a difference, you don't have time to think about embarrassment because you're in a conversation." Another said, "I never really wanted to have care and I found it really difficult at first but the girls are lovely, really nice. They chat to me as they help me and you don't think about it after a while." This meant people felt secure when being supported with personal care by staff, who behaved in a compassionate way.

All external professionals we spoke with agreed care staff they had encountered demonstrated positive caring attitudes and, when there had been a concern about a particular member of staff, the provider acted swiftly to ensure their conduct was in line with the ethos of the service.

We saw recent thank-you cards which provided further evidence of the caring attitudes displayed by staff. Cards read, for example, "Without their continuing support and advice we would not have been able to cope," and, "To the staff who have been supporting me for the past few months and become friends."

Surveys completed by people who used the service were also consistently positive about the caring attitudes of staff, for example, of 421 returned surveys, 96% of respondents stated they looked forward to their carer visiting, whilst 3% of respondents stated they were 'unhappy' with the care provided.

All people we spoke with were aware of the information in their welcome packs and felt able to play a part in the planning of their care. One person said, "I am very much a part of it and very involved." Whilst the majority of care visits were short and in order to help people in their own homes, we saw staff also helped people to maintain their independence, for example helping them to go shopping, or to the bank, or to complete as many aspects of personal hygiene as they were comfortable with.

The registered manager and care co-ordinator were aware of the benefits of providing a continuity of care to people who used the service and acknowledged this had not always happened, particularly on weekends. People who used the service and their relatives agreed that, whilst they could generally depend on a continuity of care from the same carers during the week, they were sometimes unsure who would be providing support on a weekend, or when their regular carers were unable to attend. One person's feedback was representative of a number of comments received, "The regular carers are brilliant. It's when we get alternative people. It's not their fault – the company send them without enough information." This was a source of anxiety for some people who used the service and the provider was trialling ways to improve staff retention, lower turnover and improvements to the planning of care calls, as these were contributory factors.

We saw sensitive personal information was stored securely on IT systems and the entrance to the service's office was via a secure door. This meant people's sensitive information was treated confidentially.

We found the culture to be a genuinely caring one. The service's Statement of Purpose described a focus on maintaining people's dignity and independence. We found care staff had consistently delivered in this regard, even when rota planning and the need to cover calls at short-notice presented challenges.

Good

Is the service responsive?

Our findings

The majority of people who used the service we spoke with and their relatives felt their needs were well met and that their preferences were acted on. One person told us, "I have a care plan and they've talked it through with me – it was reviewed a few weeks ago," and another said, "They came and talked to us about the care plan. They've made it very clear that if we find we need more support they can come and review things with us."

People who used the service and staff confirmed they took part in regular reviews. We saw the provider was in the process of introducing six-monthly reviews, rather than annual reviews, as had previously been the case. We saw evidence of the provider changing the support people received based on their needs, as well as liaising with external professionals to ensure people's changing needs were properly supported. We saw examples where staff had sought advice from district nurses regarding changes in medicines administration and occupational therapists regarding the using of moving and handling equipment. The provider also regularly liaised with GPs, social workers and the Speech and Language Therapy (SALT) team. We found the relevant care plans and risk assessments had been updated accordingly.

When we spoke with external commissioning and healthcare professionals they agreed the provider was more proactive than in previous years in terms of seeking advice about specific issues. One said, "It was quite difficult a year ago but they have put systems in place and the sharing of information is better. It's an improving picture."

Care files contained sufficient information for carers to undertake the necessary tasks and had been improved in terms of person-centred content since the last inspection. Person-centred care means ensuring people's interests, needs and choices are central to all aspects of care. We saw reviewed care plans had been re-written with the person's voice in mind and described the ways they wanted to receive care and not simply a list of tasks. For example, one person's care plan began with how they preferred to be addressed, whether they preferred a male or female carer and specifics about their communicative needs, such as, "I do speak quite softly and like people to speak softly to me as I do not like noise."

We found these improvements to the documentation of person-centred care to be consistent across the care planning we reviewed. The provider also told us they were planning to introduce a one-page profile for people who used the service, which would enable staff new to that person to gain a snapshot of their likes, dislikes and the things that were important to them.

Staff we spoke with demonstrated a good understanding of people's likes, dislikes and individualities, as well as their care needs. People told us they were supported by staff who enabled them to pursue their own interests, for example, playing dominoes, going to the shops and watching sport.

The provider had a complaints policy in place, which was made available to people in their welcome pack. Everyone we spoke with was aware of how to make a complaint and confident they could do so if necessary. A number of people cited instances of minor concerns they had, whereby the provider had resolved the

problem. On occasion we received feedback from people who used the service that office staff were not responsive to their queries and that sometimes office staff did not call them back. We received similar feedback from two staff we spoke with and fed this back to the registered manager. There was however a consensus of opinion that, where issues were raised, they were resolved.

At the previous CQC inspection of May 2016 we identified the provider had sometimes taken a defensive stance in response to some complaints, and needed to become more transparent and accountable in their dealing with complaints. At this inspection we found evidence this had happened. For example, we saw the registered manager had audited complaints and reminded staff to apologise in full where the provider was at fault. Similarly, a specific team had been set up to monitor complaints and quality assurance, whereas previously these responsibilities had rested with individuals. We found the system, whilst still relatively new, to be working well. A member of this team also visited the complainant a month after it was resolved to ensure there were no recurrences and that the person remained satisfied with the outcome. We found where complaints had been made they had been reviewed and responded to in line with the complaints policy, with the registered manager providing comprehensive responses. This demonstrated the provider had improved its approach to complaints and also ensured it used such complaints as an opportunity for learning.

External professionals we spoke with agreed the provider did fully look into concerns when they were raised, stating for example, "They have a history of always following things up."

The provider continued to use annual surveys as a means of routinely gathering feedback from people who used the service and staff. We saw the most recent survey results were largely positive.

Good

Is the service well-led?

Our findings

At the time of our inspection, the service had a registered manager in place. They had been registered as manager since January 2017 and prior to that were the Human Resources manager at the service. They were suitably skilled, experienced and supported by the regional director, who was previously the registered manager of the service, and who maintained day-to-day involvement. We found both the registered manager and the regional director to have a strong understanding of the policies and procedures of the service, as well as the ethos, as set out in the statement of purpose.

At the CQC inspection of May 2016 we found the provider had not always notified CQC of relevant events, such as serious repeated medicines errors. We found at this inspection that the provider had notified CQC of relevant incidents and errors and had introduced a new 'workflow' system whereby incidents were documented in a consistent manner, which included a specific question about whether CQC notification was required. The registered manager demonstrated a good understanding of CQC regulations and how they needed to maintain compliance.

At the CQC inspection of May 2016 we also had concerns about the accuracy of care plan information, with some care files we reviewed containing incorrect information pertaining to illnesses. At this inspection we found care records to be accurate, up to date and contemporaneous. We saw that annual reviews and audits were used as a means of updating care plans in line with the registered manager's expectations regarding person-centred care documentation.

Two staff we spoke with felt it was too early to judge how well the registered manager was performing, whilst the rest of staff we spoke with felt they had taken to the role well and were approachable. One staff member said, "They sit in the office next to everyone so it's a bit different but you learn a lot and they get involved if there's a difficult call or something I haven't come across before." Another member of staff said, "They have been fair all along – you know where you stand."

People who used the service provided generally positive feedback about the registered manager, and how the service was run generally. They told us, "I am very happy with the manager but don't need to contact her very often," "The manager calls regularly to see if we are okay," and, "I think it is well managed and well run." Relatives gave similar feedback, such as, "There's the odd grumble but give them their due, they sort it out."

Healthcare and commissioning professionals described an established relationship with the registered manager and regional director, saying, for example, "I have an open relationship with the manager and the care co-ordinators – they call for advice and it's good like that," "They keep us in the picture," and, "We have a good relationship with the director."

The regional director had worked in conjunction with the current registered manager to provide CQC with an action plan following the last inspection. We reviewed their progress against this plan and found they had delivered against it, with clear responsibilities and actions set out. This demonstrated the provider had

successfully addressed the breaches of legislation since our last inspection. We also saw the provider had clear plans for the future of the service and used auditing and other qualitative information to inform these plans at a strategic level.

We found morale to be good with the majority of staff we spoke with, with the only area of concern being the planning of rotas. Staff confirmed they had been invited to team meetings and we saw the registered manager and regional director were trialling different ways of involving staff despite the large size of the service. For example, it was not possible to hold all-staff meetings, so the registered manager had organised 'focus groups' for smaller members of staff to attend, with the idea that they would cascade messages to other staff. Opinions from staff we spoke with were mixed on this method but we also saw the registered manager followed these meetings up with all-staff communications. The provider had also recently used social media to share positive messages and feedback from people who used the service about specific care staff. This was managed by administrators and contained no personal sensitive information but did allow staff to view and comment on positive feedback received by their peers. This was working well at the time of inspection.

The registered manager, area supervisors and quality assurance/complaints team were responsible for a range of audits to ensure errors were identified and practice improved, for example medicines audits, care file audits and training audits. Where significant concerns were identified about the practices of a member of care staff we saw the disciplinary policy was appropriately followed. Where there were more minor errors we saw these were addressed. This format had changed recently, whereby staff were invited to an initial supervision, the focus of which was to establish what could have been done better. Whilst this was in the early stages, it demonstrated the provider recognised the need to get the right balance between not tolerating bad practice and being able to ensure staff were supported to learn from minor mistakes to improve practice. The operations manager was supportive of these changes and the management re-structure of the organisation had enabled a greater focus on reflective practice and strategic oversight.

The service provided care to large numbers of people across a diverse geographical area. This was a difficult balance and we saw the provider had trialled and continued to trial a range of means to remain effective. For example, they had introduced a new quality assurance and complaints team to ensure they dealt with complaints comprehensively but also learned from those experiences. We saw there was a well-established triage team in place, who fielded all initial telephone calls and ensured care co-ordinators were able to focus more of their time on arranging care calls. Whilst this had not directly translated to improvements in the planning of care rotas, it demonstrated the provider was keen to put in place systems that would give them long-term stability and ability to provide personal care to large numbers of people.

The registered manager had taken steps to stay abreast of best practice. They had incorporated the National Institute for Care and Health Excellence (NICE) guidance on medicines administration for adults in receipt of social care into the medication policy and arranged training sessions for staff on stroke awareness and oral health care for people living with dementia.

All staff we spoke with displayed a positive, caring attitude and it was clear in the responses from people we spoke with throughout the inspection that, whilst the provider still had improvements to make with regard to rota planning, they had ensured the culture remained a caring one that was focussed on delivering good standards of care.