Age Concern Newcastle Upon Tyne

Age UK Newcastle

Inspection report

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Ratings

Overall rating for this service	Good

Is the service safe?	Good
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 between 16 and 25 November 2016 and was announced. This was the first inspection of this service following a change in its registration in August 2016.

Age UK Newcastle is a domiciliary care agency operated by Age Concern Newcastle, which is a registered charity. Age UK Newcastle is registered with the Care Quality Commission (CQC) to provide personal care to people in their own homes. At the time of this inspection it was providing personal care to 38 people.

The service had a registered manager. 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 a legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The service had taken appropriate steps to keep people safe from harm. Staff were provided with safeguarding training which was refreshed every three years. The importance of safeguarding people using the service was discussed during staff member's regular supervision sessions. Staff we spoke with were aware of their responsibilities for recognising and reporting any signs of abuse. People we spoke with told us they felt safe.

Possible risks to the health and safety of people using the service and the staff members who supported them were assessed. Where risks were identified, action was taken to mitigate or manage these risks. This included the use of care plans to provide advice and guidance to staff on how best to support the person safely.

Appropriate systems were in place to ensure new staff were suitable to work with vulnerable people. Where the service was asked to take on a package of care, an assessment was undertaken to determine whether it was able to do this safely.

Staff received training in the safe administration of medicines and had their competency to do this assessed before they were allowed to support people. However, we found the records held in relation to medicines did not always clearly show the support people received from the service.

Staff were provided with the necessary support in terms of training, supervision and appraisal to enable them to perform their roles effectively.

The service worked within the principles of the Mental Capacity Act 2005. People's capacity to make decisions about their care and treatment was assessed by the service. Where appropriate 'best interest' decisions were made on people's behalf and involved relevant parties. People were asked to give their formal consent to their care and treatment. Care records advised staff of any support people required to make decisions, for example through the use of an advocate.

Care workers were described as kind and caring and people were very positive about the care and support they received from the service. People told us they received care from the same group of staff which provided them with the opportunity to get to know them and feel comfortable with them. Everyone we spoke with told us they would recommend the service to others.

People's needs were assessed when they were first referred to the service to establish whether the service would be able to meet them. Information gathered during this process was used to develop care plans which provided information to staff about the care and support people required. Care plans were regularly reviewed to ensure they continued to meet people's needs. Where changes were required these were made promptly.

The service had a complaints policy and procedure that people were informed about when they first joined the service. All complaints received by the service were logged and investigated. Where appropriate, written responses were provided to complainants. These outlined the actions taken by the service in response to their complaint. Annual surveys were also used to obtain feedback from people about the quality of the service. Records showed action was taken to improve the service in response to comments and complaints from people, their relatives and staff.

People and staff told us the service was well managed. There was a clear management structure in place and staff told us they were always able to speak to a senior member of staff if they required advice or support.

The service had a range of systems in place for monitoring and improving the effectiveness of the service. Action was taken to address areas identified as needing improvement. Regular reports were produced for senior management in relation to the performance and quality of the service that people received.

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.

The provider had a policy and procedure for safeguarding people from abuse. Staff received safeguarding training and were aware of their responsibilities for recognising and reporting signs of abuse.

Potential risks to people and staff were assessed and action was taken to mitigate or manage these risks.

Checks were performed to ensure new staff employed by the service were suitable to work with vulnerable people. Assessments were completed to ensure the service was able to meet a person's needs before new packages of care were taken on.

People were assisted to take their medicines safely. Although we found improvements could be made to the information available to staff to assist them in administering people's medicines.

Is the service effective?

Good

The service was effective.

Staff were provided with the support they required in terms of training, supervision and appraisal to enable them to perform their roles effectively.

The service worked within the principles of the Mental Capacity Act (MCA) 2005 to protect people's rights. People's capacity to make decisions about their care was assessed by the service and where appropriate best interests decisions were made on people's behalf.

People were supported to maintain their nutritional needs and good health and to have access to other healthcare services where required.

Is the service caring?

Good

The service was caring.

People spoke highly of the caring nature of the staff who supported them. People told us they received care from the same staff which meant they were able to build relationships with them and felt comfortable being cared for by them.

People were treated as individuals and encouraged to be as independent as possible. The service encouraged people to be involved in their care planning.

People's privacy and dignity were respected.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed when they first joined the service. Care plans were then created which provided specific instructions to staff on how best to support people in line with their preferences.

People's care and treatment was the subject of regular review to ensure it continued to meet their needs. Where there was a change to a person's needs, their care plan was updated to reflect this.

The provider had a complaints policy and procedure in place. Complaints were taken seriously and investigated thoroughly.

Is the service well-led?

Good

The service was well-led.

The service had a registered manager who was aware of their role and responsibilities.

A range of systems were in place to monitor and develop the quality of the service.

People and staff were complimentary about the management of the service and felt able to voice their opinions and raise concerns.

Age UK Newcastle

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.

This inspection took place on 16 November 2016 and was announced. The provider was given two working days' notice of the inspection as the service is a domiciliary care agency and we needed to make sure the provider's representative was available to assist us with this inspection. We also made telephone calls to staff, people and their relatives on 23, 24 and 25 November 2016.

This inspection was undertaken by one adult social care 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.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We also contacted other agencies such as local authorities and Healthwatch to gain their views of the service.

During the inspection we spoke with five people who used the service by telephone and four relatives. We spoke with staff including the registered manager, the chief executive, the home support manager, the head of quality and three care workers. We reviewed a sample of seven people's care records, five staff personnel files and other records relating to the management of the service.

Good

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. They told us they had regular care workers who were usually on time. Comments included; "I see the same ones and like others my age, I don't like change" and "They let us know (if they are going to be late) and are regular". Relatives we spoke with also felt their family members were safe using the service and that they were kept informed. One relative told us they felt confident leaving their relative with the care worker, stating; "I can go to the shop, I trust them".

The provider had a safeguarding policy and procedure in place, which were available for staff to refer to. These provided information about the different types of abuse people may suffer, the potential signs they may display and the provider's responsibility for recognising and reporting concerns. The policy also clearly stated the provider's responsibility for notifying the Care Quality Commission (CQC) of any safeguarding incidents and of working with other agencies to protect people.

We reviewed the service's safeguarding records and found four incidents were logged during 2016. These incidents had been reported to other agencies such as the police and local authority safeguarding adults' team. There was also evidence that incidents had been investigated internally and, where appropriate, notified to the CQC.

The staff training matrix indicated all staff members received training in relation to safeguarding people from abuse and that this was refreshed on a three yearly basis. Potential staff members were also asked about their knowledge of safeguarding during their initial interview and it was also discussed with staff during their supervision sessions.

The service had a whistleblowing (exposing bad practice) policy. This provided information to staff about the process for reporting concerns and included details of an external charity that specialised in whistleblowing. This meant if staff did not feel able to report concerns directly to the service they had contact details for an alternative agency.

Staff we spoke with told us they had received safeguarding training and were aware of the importance of protecting people using the service from potential abuse. They were also aware of the whistleblowing policy and told us they would report any concerns to the office or their manager.

We looked at how the service identified and managed risks. We found the service had a business continuity plan. This covered the action to be taken in order to continue the service in the event of an emergency. There were plans in place to respond to emergencies such as flooding, loss of staff and severe weather.

People's care records showed an initial assessment was completed during which potential areas of risk were identified. Where the person then chose to use the service, more detailed risk assessments were completed in relation to falls, the home environment, personal handling, medication and finances, where applicable. The assessments identified risks to the person as well as to staff members. Where a risk was identified we saw evidence action was taken to manage or mitigate the risk, for example through the introduction of a

care plan. Care records we reviewed showed risk assessments were reviewed and updated on a regular basis.

We spoke with the home support manager about staffing. They told us when the service was asked to take on a new package of care an assessment was first completed to determine whether they could safely meet the person's needs. The home support manager explained the person's requirements would then be checked against the master rota to establish whether they were able to accommodate the person's visit days and timing preferences. We were informed the service would only agree to a package if they were able to offer a consistent team of staff to fulfil it.

The home support manager told us the customer care supervisors were responsible for producing rotas on a weekly basis. These were checked against the master rota to ensure calls were allocated in line with people's individual care packages. Copies of rotas were sent to people and staff for them to review. People and relatives we spoke with confirmed this.

Staff we spoke with told us they received a copy of their rota on a weekly basis. Where any changes were made, for example if the service took on a new care package, staff told us they were informed by staff in the office.

We reviewed the recruitment files for five staff members who had been recruited in the last 12 months to determine whether appropriate systems were in place for the recruitment of new staff. We found all potential staff members were asked to complete an application form. References were sought to verify the information supplied in application forms and to assess their character and experience. Checks were also performed with the Disclosure and Barring Service to determine whether or not applicants had a criminal record or were barred from working in a social care service.

We asked the registered manager about the support provided to people to manage their finances. They told us where a person required assistance with their finances this was generally only for small items purchased on their behalf, such as groceries and clothing. Where a person needed such support, a financial risk assessment was completed. Specific guidance was then provided in the person's care plan about the support the person required from staff in this area.

We reviewed the financial records for one person using the service. These consisted of a paper record of monies spent and receipts for purchases which were kept in the person's care file. We found this record included the date, the amount of money provided, the amount spent and any change given. The record also had space for both the person and the staff member to sign. We checked a selection of receipts against the record and although the amount spent and the change given tallied there were inconsistencies with the amount provided. For example one entry stated £10 had been taken but the receipt showed £20 cash had been provided to pay for the goods purchased. We raised this with the registered manager. We were informed a specific named care worker was responsible for withdrawing money on a monthly basis from the person's account. This was then used to make purchases for the person for the rest of the month. We highlighted the fact the records available did not clearly reflect this. We also found financial transactions for this person had not been checked and audited for a number of months. The registered manager agreed the records were not clear and that they should be audited on a monthly basis the same as people's daily notes and Medicine Administration Records (MARs). They also told us a new form for recording financial transactions had been introduced and this included a running total of the money held on the person's behalf. Following the inspection the registered manager assured us this new form had been introduced into the person's home and clear records were now being kept to reflect the money withdrawn on the person's behalf each month.

We looked at how the service managed medicines. We saw where people were able, they were encouraged to manage their own medicines and a risk assessment was completed to ensure this was safe. People's care records contained a list of their current medicines including how and when these were to be taken.

Staff received medicines training as part of their initial induction. Their competency to administer medicines safely was then assessed before they were allowed to administer medicines to people on their own. Staff members' competency in this area was assessed on a regular basis and they received yearly refresher training.

Where the service supported people with their medicines, MARs were produced by staff. We found these were hand written but had not been checked and signed by two staff to ensure their accuracy, which is best practice. MARs were returned to the office on a monthly basis and audited by senior staff. At the time of the inspection the MARs for the previous month had just been returned and were in the process of being audited. We reviewed a selection of these. In general we found MARs did not always provide clear instructions to staff about the support the service provided to people. For example in one of the records we reviewed we saw the person required one medicine twice per day, once in the morning and once at night. The MARs showed this person had only received this medication in the mornings. We highlighted this to the registered manager. We were informed the service only completed one of the calls to this person and as such they were only responsible for administering the person's morning medicines. We highlighted the fact that this was not clear from the person's MAR. The registered manager agreed the MARs could be improved. They told us the service was planning to produce printed MARs sheets which would better reflect the level of support the service actually provided to people with their medicines. Following the inspection we were informed by the registered manager that changes had been made to this person's MARs to accurately reflect the support they received from the service with their medication. We were also assured that handwritten MARs were now being checked and signed by two staff members.

Good

Is the service effective?

Our findings

People and relatives we spoke with told us the service was effective. People felt the staff who cared for them were experienced. Comments included: "Older ones have lots of experiences and they are all very personable and friendly", "They are well trained, they know what I need" and "They are always going for supervision and training". People and their relatives also told us they had care plans in place which detailed their needs and that staff kept them informed. For example one relative explained "If [relative] has an infection they tell you".

We reviewed the staff training records. We found most staff were up to date with mandatory training such as safeguarding and moving and positioning. The service used a computerised system to monitor staff training. This system was monitored by the administrator and flagged up when staff were due for further training. In addition to the standard package of staff training, we saw some staff members had also undertaken additional training in areas such as catheter and stoma care, end of life care and epilepsy. The home support manager told us this meant the service was able to accept a wider range of care packages.

We found new staff employed by the service were required to complete an induction which was aligned to the Care Certificate. The Care Certificate was introduced in April 2015 and is a standardised approach to training for new staff working in health and social care. As part of their induction, new staff members shadowed more experienced members of staff until they were deemed to be competent to carry out their role effectively on their own.

All of the staff we spoke with told us they had received an induction when they first started to work for the service. We were informed this had involved familiarisation with policies and procedures, the completion of training and the opportunity to shadow an experienced member of staff. They confirmed after this they were provided with refresher training on a regular basis. One of the staff members we spoke with also told us they had also been offered additional training.

The provider's policy for supporting staff included a commitment to providing staff with a supervision session on a three monthly basis. We were informed this included individual supervision sessions, group supervisions and observations. The service used an electronic system to schedule and monitor supervision sessions for individual staff members. We found areas covered during supervisions included health and safety, safeguarding, training needs and a discussion about the staff member's well-being. The records we reviewed showed supervisions were taking place on a regular basis for all staff members. Staff members we spoke with confirmed they received regular supervision sessions and an annual appraisal and that they felt well supported in their roles.

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.

Care records showed people's mental capacity was assessed when they first joined the service. Where concerns were raised about a person's capacity to make a particular decision, we saw evidence a "best interests" decision had been made on the person's behalf. Records showed relevant healthcare professionals and people's representatives had been involved in these decisions.

People were asked to provide their formal consent to their care and support. We saw people had signed consent records confirming they had provided information used to develop their care plan, had received a copy of both their assessment and care plan and were happy and consented to care being delivered as described. People were also informed care workers would check for their consent at every visit and reminded that they were able to withdraw their consent at any point.

Care records contained information about any assistance a person required to make decisions about their care and treatment. For example in one of the records we reviewed it noted the person's husband should be involved in all decision making. Another of the records stated '[Name] is very capable of making decisions but they have an advocate who will assist them if necessary'. In another record we saw a person had appointed a family member as their Lasting Power of Attorney (LPA), therefore giving them the right to make decisions on the person's behalf. A copy of the LPA was contained within the person's care records and records showed this representative had been consulted about and involved in all decisions about the person's care. Training records also showed staff had received training in relation to the MCA and staff members we spoke with confirmed this.

From the records we reviewed and our discussions with people, relatives and staff we established the vast majority of people using the service only required minimal assistance with their food and fluid intake. Where people had specific dietary needs this was identified in their care records. For example in one of the records we reviewed it noted 'I am diabetic so need to watch my diet, I am not supposed to eat fried foods because I have a gall stone and I prefer not to eat meat and I do use Quorn products'. Staff training records showed all staff had received training in relation to hydration and nutrition. Some staff had also received training which allowed them to support people who received their food and fluids through a Percutaneous Endoscopic Gastrostomy (PEG) feeding tube. Although at the time of the inspection the service was not supporting anyone with a PEG feeding tube, the home support manager confirmed they had previously and that specific training had been provided to staff to enable them to do this safely.

People's care records contained contact details for relatives and relevant health and social care professionals. The registered manager explained how the service worked in conjunction with other healthcare professionals to ensure the care people received was effective. For example, they told us they regularly worked with occupational therapists and wheelchair services when people required assistance with their mobility.

Good

Is the service caring?

Our findings

People and relatives we spoke with were positive about the service and the care they received from staff. Comments included; "They're (the staff) all good", "They talk to [relative] like they are a person, they treat them as an equal and they have good banter" and "They are kind". Everyone we spoke with told us they received regular care workers. People and their relatives told us this meant they had gotten to know them and felt comfortable with them.

Care plans we reviewed contained a section for staff to complete which asked people to provide detailed information about their background. However in all of the care records we reviewed we found this was not fully completed. We discussed this with the registered manager. We were informed that although staff asked people to provide this information they were generally reluctant to do so, stating that staff did not require this information. As a result of this feedback, we were informed the service had reviewed and refined the care and support plan. We were provided with a copy of the new documentation the service intended to introduce. We found this was more focused on the care people required and only asked them to share pertinent information required by the service to ensure they were able to safely meet people's needs.

People's care records contained details of their likes and dislikes as well as information about their immediate support network and things which were important to them. People were asked about their daily routines and preferences. The service also asked people whether they required assistance to maintain contact with friends and family members or to access their local community.

Staff we spoke with told us there was always a care plan in place in people's homes. They said this provided information about the person and their needs as well as detailed information about the support they required during each call.

People we spoke with did not feel rushed by staff during calls and confirmed staff always checked whether there was anything else they needed before they left. One person said staff would "Bend over backwards" to assist them and a relative told us "When I'm out they do the exercise routine and make sure [relative] has what they need before they go".

Staff we spoke with told us they were allocated sufficient time to provide people with the support they required, whilst still having time to talk to them and get to know them. One staff member also told us if they felt they were not allocated sufficient time they could raise this with the office. They explained the office staff would then arrange to complete a review of the person's care to see whether their package of care was appropriate for their needs.

The service was aware of the need to respect people's preferences. People's care records captured details of any preferences people had in relation to their care and staff were aware of the importance of respecting this. People we spoke with felt if they had any specific preferences these would be respected and they were able to give us examples. For instance, one of the people we spoke with told us they had requested male care workers and that this had been respected. They went on to explain how the service had continued to

do this even when their regular care workers were not available. Another person told us the service had responded promptly to their request to change the staff who supported them.

We found care plans were generally written in the first person and clearly showed the people and their representatives had been involved in creating these. Care records contained information for staff to assist them in communicating effectively with people using the service. For example, one of the records we reviewed noted the person had both visual and hearing difficulties and therefore advised staff to; "Speak to [name] from the same room…. and stand in front of them". Another noted "English is [name's] second language. Verbal communication has to be spoken slowly for [name] to understand".

Staff used daily communication logs to record details of the care and support they had provided to people during each call. We saw these logs were returned to the office on a monthly basis where they were checked and audited by senior staff. Where issues were identified we were advised these were discussed with individual staff members. For example, at the time of the inspection senior staff were in the process of auditing records for the previous month. We saw these audits had identified that a care worker was scribbling entries out. We were informed this had been noted to be discussed with the staff member.

Staff we spoke with were aware of the importance of involving people in their care and of offering them choice. They told us when providing care to a person using the service they would always first explain what they were going to do and gain the person's consent. Staff explained how they encouraged people to be as independent as possible and where able to do things for themselves. For example, when providing personal care one staff member told us they would first ask the person what they needed assistance with. They then told us they would encourage the person to do things for themselves, such as wash their hands and face if they were able.

Staff we spoke with were aware of the importance of respecting people's privacy and dignity and were able to give examples of how they did this. For example, one staff member explained how they would cover people over when providing personal care. Another staff member explained they would do this by asking people if they wanted them to leave the room when they were dressing or in the shower.

People and relatives we spoke with confirmed staff were respectful and maintained people's privacy and dignity. One of the people we spoke with told us the service had assisted them to get a wet room installed to make it easier for them to receive personal care. They also told us staff respected their wishes when providing care.

We asked about the provision of end of life care. We were informed the service did on occasion provide this. Training records showed some staff members had received specific training in relation to the provision of end of life care and staff we spoke with confirmed this. As part of the initial assessment of a person's needs, the service asked whether people had made any advanced decisions including in relation to their wishes around being resuscitated. Where applicable, copies of any advanced decisions were recorded to ensure staff and other healthcare professionals acted in line with the person's wishes.

Good

Is the service responsive?

Our findings

People and relatives we spoke with told us the service was responsive to their needs. They said their care plans were reviewed annually and they were involved in this. People told us they received a copy of their weekly rota and if they wanted to make changes to this they were able to. For example, one person said, "They send a rota and if I am not happy with it then I phone them for example to cancel a session to go to a scan". Another person told us they had made changes to their rota; "I had one or two (staff) I was not keen on and I told them". Although none of the people or relatives we spoke with had any complaints about the service they told us they would know who to contact if they did.

An assessment of a person's needs was completed when they were first referred to the service. These assessments covered areas such as the person's physical and mental health needs, their medical history, contact details for their next of kin and any relevant healthcare professionals as well as details of their personal history. Information gathered during this initial assessment was used to develop care plans designed to provide advice and guidance to staff on how best to support the person. We saw evidence people and their relatives had been involved in this process and people we spoke with confirmed this.

Care plans were generally written in the first person and included details of people's preferences for how they would like their care and support to be delivered. For example one of the records we reviewed stated; 'I like to be left alone in the bath for a short while to relax. When I am ready I will call out. I need assistance to wash my back and also my hair as required'. Another record noted 'On social outings I would prefer the care worker not to wear their uniform'. Care plans also provided staff with step by step instructions on how to deliver care to the person in a way that would meet their individual needs.

In the care records we reviewed we saw evidence regular reviews were completed to ensure people's care plans were accurate and provided a true reflection of the care and support they required. We were informed when a person first joined the service an initial telephone review would be conducted after a three week period to double check the person was happy with the care being provided. This was then followed up with a more formal eight week review during which a member of staff would attend the person's home. After this, people's care plans were then reviewed at least annually. The service used a computerised system to identify when each person's review was due. We saw where there had been a change to a person's needs their care plan was updated to reflect this.

We asked about the support offered to people and staff outside of normal office hours. We were informed the service operated a 24 hour on call service. This was manned by the home support manager or one of the customer care supervisors. Staff members we spoke with confirmed this to be the case and told us they were always able to speak to someone for advice and guidance. One staff member told us senior staff were always willing to provide reassurance, offer advice and where appropriate would also come out to assist staff.

We reviewed the provider's complaints log. Seven complaints were recorded in the log for 2016. The log covered the date each complaint had been received, the complainant's details, the nature of the complaint

as well as the action taken by the service in response to the complaint. Entries we reviewed were clear, detailed and professional, with evidence of acknowledgement and outcome letters for complainants where appropriate.

We found the service issued an annual questionnaire to people and staff in order to get their views and opinions of the service. We reviewed the results from the survey issued in June 2016. We found of the 177 questionnaires issued only 59 had been returned. The responses received were largely positive throughout and showed an improvement in all areas from the results of the previous year. The findings of the survey had been analysed and a number of recommendations made. It was noted that although overall people were satisfied with the service and the care they were receiving, improvements could still be made. Outcomes included feedback to staff and people, and improvements to the continuity of care with people being informed of any changes to their rota promptly. The service had also committed to following up a number of comments and concerns raised by people in the questionnaires. During the inspection we found evidence the service had engaged with these people on an individual basis to explore the concerns they had raised and to identify ways to address these.

People were also asked for their feedback during regular reviews of their care. We found people were largely complimentary about the service they received. This corroborated the findings of the recent survey, during which people 83% of people who responded stated they were very satisfied with the service.

Good

Is the service well-led?

Our findings

People and relatives we spoke with felt the service was well-led. All told us they would recommend the service to others and that they could not think of any particular areas for improvement. Comments included; "It's very good, an excellent service", "They are well run and I've recommended them" and "They are very good". Although not all of the people we spoke with knew who the registered manager was, people and their relatives knew who the office staff were and who to contact if they required assistance or had a complaint.

The service had a registered manager. They understood their management responsibilities and registration requirements, including notifying the Care Quality Commission (CQC) of events which affected the service and their obligations under the duty of candour regulation. The registered manager was supported in their role by the home support manager, the head of quality and the chief executive. We found the registered manager had delegated responsibility in a number of areas, such as the completion of staff supervisions and appraisals to assist them in the effective running of the service.

We raised the issues we had identified with the Medicine Administration Records (MARs), finance record and the non-completion of some sections of people's care plans with the registered manager during the inspection. The registered manager was able to provide evidence of action already taken by the service to address some of the concerns we highlighted. For example, we were provided with a copy of the new care documentation that was due to be introduced. We were informed the service had already identified that large sections of care documentation were not being completed and had obtained feedback from staff and people to ascertain why this was. Action had then been taken to produce new documentation which was more focused on people's needs and asked them to provide less background information, which had been people's preference. We were assured the service was planning to introduce computer generated MARs to clarify those medicines staff were responsible for administering. New arrangements were also in place to ensure financial records were audited on a more regular basis and provided greater clarity about transactions completed on behalf of people.

The registered manager told us both the board of trustees and the chief executive were actively involved in the management of the service. We were informed the service had approached Skills for Care who had delivered a workshop to the board and other members of senior management. This had provided them with a greater understanding of the requirements of the service as part of its registration with the CQC. As a result we were informed the board were now more aware of how they could contribute to improving the service. The registered manager told us they felt able to approach both the chief executive and the board with suggestions or concerns about the service and that these were taken on board and action taken in response. We saw the chief executive was also involved in conducting annual reviews of policies and procedures to ensure they remained appropriate.

All of the staff members we spoke with told us they felt supported in their roles. Care staff told us they were always able to speak to a member of senior staff for advice or guidance where they required this. Staff confirmed they had regular contact with their managers including through regular supervision sessions and that they felt comfortable to voice their opinions and raise concerns.

There were a range of systems in place for monitoring the effectiveness and quality of the service. These included the completion of regular audits of records such as daily notes and MARs. There was a monthly analysis of records such as complaints, safeguarding and health and safety. Reviews of care records were also completed by the registered manager. A self-assessment tool had also been developed based on the CQC inspection process. This was used by the service as an internal measure of their compliance with the CQC regulations. In addition, processes were in place to obtain feedback on a regular basis from people using the service and staff members. We found evidence where areas for improvement were identified, action was taken to address these. Regular reports were also produced for both the board and the chief executive outlining the service's performance in key areas.

During the inspection we spoke to the chief executive about their role and the role of the board of trustees. The chief executive provided information about other services provided by the charity which people using the service were also able to access. These included an advice line, day services, dance and fitness classes and access to befriending services. The chief executive also told us about the work the charity and service undertook with other organisations and their plans for the future. These included on-going work with local GP practices and hospitals in relation to ill health prevention and trying to reduce hospital admissions. There were plans to introduce a nurse specialist to increase the service's ability to take on more complex packages of care. The chief executive told us they were also working with the NHS to try and were hoping to get agreement for a specialist dementia nurse to be seconded. We were informed this was as part of a project to work with people who had just been diagnosed with dementia to get a better understanding of the support they required following their diagnosis.