First Call Healthcare Limited

# First Call Healthcare Limited

## Inspection report

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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

The inspection took place on 28 and 29 June 2016 and was announced. We had last inspected First Call Healthcare Limited in August 2014. At that inspection we found the service was meeting the legal requirements in force at the time.

First Call Healthcare Limited is a domiciliary care agency that provides personal care and support to people living in their own homes. At the time of our inspection services were provided to 14 people, who were mainly older people including those who were being cared for at the end of their lives.

The service had a manager in post who had applied to become the 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 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 that care was appropriately planned to protect people's welfare and personal safety. Steps had been taken to reduce the risks of avoidable harm and safeguard people from being abused. Staff understood their roles in recognising and reporting any concerns about people's safety.

There was sufficient staffing capacity for people to be provided with safe and consistent care. New staff were properly checked and vetted to make sure they were suitable to be employed to work with vulnerable people. Staff were supervised and given training to enable them to meet the needs of the people they cared for.

Where required, people received assistance to meet their nutritional needs including support with eating and drinking. People were well supported in meeting their health care needs and staff worked in a co-ordinated way with families and other professionals. However, the arrangements for managing people's prescribed medicines were not fully robust.

People and their families were consulted about their care and how they preferred to be supported. Wherever possible, services were provided flexibly and adapted in line with people's needs and requests. Staff confirmed they were given enough time and information to provide people with effective care.

Supportive relationships had been developed between staff and the people and families they worked with. Staff were described as having a caring approach and being respectful of people's privacy, dignity and independence. A number of relatives spoke positively about the personalised care they felt their family members received.

Care plans were tailored to the person, had been agreed with them and their family, and were kept under review. Good communication systems were in place to keep check on people's well-being and respond to

any concerns. People were informed about the complaints procedure and were regularly asked for their views about their care experiences.

The manager promoted an open culture and provided staff with leadership and support. Methods to monitor the quality of the service were in place, including routine checks to ensure staff met the provider's standards. A commissioner of the service spoke highly of the way the service was managed and operated.

We found one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 relating to the safe management of medicines. 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. Accurate records were not kept of people's prescribed medicines and their administration. A clearer system of assessing the competency of staff in handling medicines was also needed.

The service had made suitable arrangements to prevent people from being harmed and abused.

There were sufficient staff employed to care for people safely.

### Is the service effective?

**Good**

The service was effective.

Staff were provided with the training and support they needed to carry out their caring roles.

Care was given with people's consent to ensure their rights were upheld.

The service supported people, where required, in meeting their health care and nutritional needs.

### Is the service caring?

**Good**

The service was caring.

Staff had formed caring relationships with people and their families.

People were treated respectfully and cared for in a dignified way.

Information about the service was provided and people were encouraged to make decisions about their care.

### Is the service responsive?

**Good**

The service was responsive.

People's needs were properly assessed and individualised care plans were in place.

When requested, the service was able to assist people with meeting their social needs.

Any complaints about the service were taken seriously and were appropriately responded to.

## Is the service well-led?

Good

The service was well-led.

The manager was committed to working inclusively with people, their families and staff.

There was good governance of the service and staff were well supported.

Measures were in place to assess and assure the quality of the service that people received.

# First Call Healthcare 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 was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

The inspection was announced and took place on 28 and 29 June 2016. We gave 48 hours' notice that we would be coming as we needed to be sure that someone would be in at the office. The inspection was carried out by an 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 contacted a commissioner of the service and received positive feedback.

During the inspection we talked with two people who used the service, four relatives, the provider, the manager, a care co-ordinator and four support workers. We looked at five people's care records, staff training and recruitment records and reviewed other records related to the management of the service.

Requires Improvement

# Is the service safe?

## Our findings

We checked the service's arrangements for managing people's prescribed medicines. Staff were given medicines training which they updated annually via e-learning. Some elements of assessing how staff handled medicines were included within spot checks, however there was no means of ensuring a full assessment of each staff member's competency was carried out.

A minority of people using the service received support with their medicines. The manager told us this ranged from verbal reminders to staff administering medicines. We saw there was some evidence of medicines routines in care plans, though the extent of support each person required was at times contradictory or unclear. People and their relatives expressed no concerns about medicines administration. One person told us, "They put them (medicines) out for me, I take them, it works for me."

We found that lists of people's current medicines were not in place and medicines administration records (MARs) had not always been accurately completed. For instance, staff had signed four times a day for a medicine that was only to be given in the mornings. An incorrect code had also been used in the MARs when staff had prepared medicines for a person to take at a later time. There was no current system for auditing the MARs and we concluded that people could not be fully assured of receiving their medicines safely.

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

The manager informed us that practical training sessions on administering medicines and completing MARs had been booked for staff for the following week. They had also amended the MARs to make the codes clearer and arranged for the records to be returned to the office for auditing purposes.

People and their relatives told us they felt safe and comfortable with their support workers. One person said, "Yes, absolutely." A relative commented, "100% safe. I am confident if I wanted to go to the shop my [family member] is in safe hands." Another relative said, "Everything is really good." A commissioner of the service told us, "Yes, I trust the service is safe as we have had no reports of any abuse or risks regarding care workers or office staff members."

People were given information in the guide to the service that informed them about their rights to be safeguarded from abuse. The service had policies and procedures on safeguarding and whistle-blowing (exposing poor practice) in place. These were introduced to staff during their induction and were set out in the staff handbook, including contact telephone numbers for local safeguarding authorities. Staff were also provided with a code of conduct that included the process for the safe handling of people's money. We were informed that none of the people using the service at present needed any support with their finances.

Staff undertook safeguarding training annually and those we talked with understood their responsibilities in preventing and reporting abuse. They told us, "I'm confident I'd report anything straight away, though I've never had cause to", and, "The other staff I've worked with are caring and have a nice attitude. If they didn't

treat people properly, I'd report it." We were shown that a 'duty of candour' policy had been developed and details were being included in the next staff newsletter to raise their awareness. The duty of candour requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

We found there had been three allegations of neglect in recent months which had involved care and support visits being missed. These had created the potential for a person using the service to come to harm as they had not received the support they required. The manager told us that unsafe care would not be tolerated and these incidents had led to disciplinary action being taken. The provider and manager were reminded of their responsibility to ensure such allegations were notified without delay to the Care Quality Commission and reported to the local safeguarding authority. The safeguarding issues were reported retrospectively during the inspection.

Steps were taken to ensure people's personal safety. A range of risks associated with care provision were assessed, such as support needed with moving and handling, medicines, finances, nutrition, safe use of equipment and environmental factors. People's vulnerabilities in respect of their mental health, capacity to make decisions, psychological well-being and any safeguarding issues were included in the assessment. We saw that measures to reduce identified risks had been agreed with the person, or their representative, and were built into care plans. Examples included support with maintaining skin integrity, continence management and preventing social isolation. Where people needed two staff at each visit to safely support them, this was specified.

The service had an accident and incident reporting system and we were told none had been logged over the past year. Checks were made that people had the necessary aids and equipment to safely deliver their care and that staff were appropriately trained to use them. People and their relatives told us their care workers were mindful of using personal protective equipment, where necessary, when providing personal care. One person said, "They use both gloves and aprons and sometimes use a special hand wash."

We found that all necessary pre-employment checks were conducted when the service recruited new staff. These included completion of an application form, obtaining proof of identity and a check made with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruitment decisions to prevent unsuitable people from working with vulnerable groups. Two references were sought, including one from the last employer and applicants were interviewed. Applicants also completed questionnaires designed with scenarios to test their knowledge and values.

People and their relatives were generally positive about the reliability of their care workers. One person said they had experienced missed visits when their service had first started two to three years ago and added, "It's quite good now, not missed one for a while." Relatives told us that on the whole care workers arrived on time and had only missed visits due to bad weather. Their comments included, "They are spot on", "Always on time, within five minutes, they've never missed a call", "I don't think they have missed a call", and, "They have missed a call once or twice due to snowy weather. They rang and checked this was okay and that we could manage, which we could."

Relatives told us the service always contacted them if care workers were running late or about any other changes. This was confirmed by a commissioner of the service who told us, "Care workers have a high standard of time-keeping skills." They said there had been one occasion the previous year when a person was not informed that their worker was running late due to unforeseen circumstances. They told us this had not happened again and that workers were aware to contact the person or their family if they knew they were going to be delayed.

The staff team consisted of the manager, a care co-ordinator and 27 care workers. The service operated across the 24 hour period, with people receiving visits from one hour duration to overnight care. The manager reported there was sufficient staffing capacity and a number of new care workers had been employed with a view to expanding the business. There was also scope within the team to accommodate new services and to provide cover for holiday and sickness absence. Rosters were planned in advance and sent to care workers on a weekly basis. Staff confirmed this and told us they were informed of any changes in a timely way. An on-call system was worked by the manager and care co-ordinator outside of office hours in the event of an emergency and for staff to get advice or support.

Good

# Is the service effective?

## Our findings

People told us their care was managed effectively. One person told us, "My carer was doing it perfectly, getting me up in a morning, into the shower, dressing me and putting dressings on my leg." People and their relatives felt that their care workers were well matched and considered them to be trained and skilled. One relative commented, "I know our carer goes for training." Another said, "Yes, they are very good."

Staff told us they were given enough time, information and training to help them provide people with effective care. Their comments included, "I always read the care plans and ring the office if there's anything else I need to know", "With our longer term clients we've had time to get to know them and for them to become familiar with us", "There's different training options available and we get good support from the manager", and, "I'm up to date with mandatory training and will be doing my diploma in the future."

Records confirmed that new staff were given induction training to prepare them for their caring roles. This included shadowing experienced staff, introduction to the provider's policies and procedures, and undertaking 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. All staff were given a handbook that set out the service's key policies and the standards and conduct expected of them as employees.

Care workers were given mandatory training that included assessments of their knowledge and understanding and this was updated annually. The courses covered safe working practices such as moving and handling, food hygiene, health and safety, and infection control. Further training was planned to enhance staff skills on topics including catheter care, handling medicines, resuscitation and specialist feeding techniques. These were practical sessions which were being provided by the manager, the operations manager, and a new care co-ordinator, who were appropriately trained and experienced in delivering training. Eight staff had qualifications in care and other care workers were being offered the opportunity to study for diplomas in health and social care. A commissioner of service told us they believed the service would provide staff with any additional training required in order to meet people's needs.

The manager acknowledged individual supervision for staff had lapsed prior to them being in post and they told us that since starting three months ago, they had supervised most of the care workers. A schedule was now in place for supervisions to be given every 12 weeks and for annual appraisals to take place. The manager explained a decision had been taken to introduce a delegated system, with the current and new care co-ordinator being allocated staff to supervise. Spot checks, where care workers' practice and performance were observed whilst providing care, had also been brought up to date. Care workers told us that they were now receiving regular supervision and those who had worked for the service over a year confirmed they had been provided with appraisals.

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 we talked with told us their care workers asked them for consent before undertaking any tasks and involved them in decisions about their care. One person said, "Yes, I tend to take charge". Another person said, "They will always ask me (for permission)." Relatives agreed that care workers asked for consent. One relative told us, "Yes, they do, [family member] didn't want their nails clipped so they left it. When the carers came back the next day they were happy for them to do it." Another relative said, "They ask [name] what they want and ask before they do anything."

The service's care documentation prompted consideration of whether the person had mental capacity to make decisions about different areas of their care and treatment. Information was also obtained about any appointed representative who had power of attorney status, to make decisions on behalf of the person. We saw that people and their families had been involved in and agreed to the content of their care plans, including any strategies to manage risks. The manager told us that all care was given with consent and no-one currently using the service had restrictions or 'best interest' decisions in place. We noted, however, that no training had been provided for staff in the MCA to make sure they understood the implications for their practice. The manager confirmed this training would be arranged.

The care co-ordinator told us two people using the service had fluctuating mental health and on occasions presented with distressed or unpredictable behaviours. They explained that they arranged the same care workers who were familiar to the person and, where necessary, for two workers to provide support at each visit. Restraint or excessive control was not used and care plans had been updated with an emphasis on diversional techniques to prevent potentially harmful behaviour. One care worker we talked with described how they had found the use of tactile communication worked well with a person prior to assisting them with personal care.

Nutritional risks were assessed and, where needed, staff provided people with support with meals, drinks and snacks. We saw support, including offering choices of food and drinks, and helping a person to prepare meals, was included in care plans. The manager told us food and fluid charts were available and would be used if staff needed to monitor anyone's intake. We were told some staff had been trained in caring for people at the end of their lives. Some had also received training in PEG feeding (where food and supplements are provided through a tube in the abdominal wall into the stomach) when caring for a person who required this. A minority of people we spoke with said they received support at meal times. One person told us, "They used to make breakfast cereal, perfect." A relative stated, "Carers will help with supporting my [family member] to eat and drink and they are happy with this."

We saw medical history information was obtained from referrers and as part of the service's assessment process. This included details of how particular health conditions affected the person and co-ordinated working with district nurses, palliative care nurses and other healthcare professionals. Future decisions of people's instructions not to be resuscitated were also documented.

The manager told us care workers were vigilant in recognising any concerns about people's health or demeanour and reported these to the office. For example, staff had recently informed the manager about a person having had a very uncomfortable night. The manager had then followed this up and arranged for a profiling bed to be quickly provided for the person's comfort.

People told us their care workers provided appropriate support when the input of health care professionals was required. One person commented, "A carer called 111 once for me." Relatives also said that effective health care was provided. Comments from relatives included, "Once a care worker sent for a palliative care

nurse and let me know", and, "Yes, the carer went to hospital with my relative. The carer was brilliant, and explained to [family member] what was happening." Relatives told us the staff kept them informed of any health issues. One said, "Carers will inform me if they identify any problems and I will contact the appropriate health care worker."

The main commissioner of the service was a charitable organisation that provides care for people with life-limiting conditions. This commissioner told us, "Since [manager] joined First Call, the response time in informing us of their capacity and if they are able to take on new care packages has dramatically improved. This has benefited a lot of patients and their families as we have been able to work together to provide the much needed care sooner. Patients have also been able to be safely discharged from hospital/hospice to home care, which is the main aim of our service to grant the patient's wishes of being at home. I believe all patients that are cared for by First Call carers are provided with a high standard of care throughout the package."

Good

# Is the service caring?

## Our findings

The people and relatives we talked with told us their care workers had a caring approach. We received many positive comments including, "They are very caring people", "They have a good chat, they're good with him", and, "Very caring." Several relatives told us they felt the care provided was personalised. Comments included, "It's as though they are relatives of theirs; they treat him how they would look after their own", "They are not just carers, they care about him. If they get a smile from him, it makes their day", and, "They come in with cakes and biscuits, make him a cup of tea, they sit with him."

There was a mixed response when people and their relatives were asked if they had regular care workers. The majority of comments indicated that efforts were made to provide consistency of workers. For example, "I have the same carer during the week. I have different people when I go to my two social events", "We have two regular carers for a week, then swap over and two regular carers come", "Yes, two come four times a day, they are the regular carers. The agency also tries to keep the same carers in when the regular ones have a day off", and, "More regular than not."

One person, who had recently left the service indicated there were not enough male staff employed and a relative told us, "We used to get the same ones, most of time, there are new ones now." The manager told us the service aimed to give people continuity of care and, for practical reasons, to give them care workers who lived locally. Wherever possible they tried to introduce the main care worker to the person and their family before their care service was started. People were asked if they preferred support from males or females and this was checked when organising cover for the absence of regular workers.

Consideration was given to matching people with workers who were skilled in meeting their needs. For example, support provided to a person with mental health needs was given by a care worker who was suitably experienced. The service also provided rosters to those people who requested them so they would know in advance which care workers would be visiting them each week. The care co-ordinator commented, "People are always given choices and we will change their workers if they want. We get a lot of positive feedback from people and their families."

The manager explained that they would not compromise the amount of time given to people at each visit to ensure they received good quality care. Visits for personal care were arranged to be for at least an hour so that people were not rushed and staff had enough time for social interaction.

Care workers told us they tended to work with a small number of people and described being able to get to know each person well and form relationships with them and their families. They recognised the importance of providing dignified care to people as well as taking account of the needs of their relatives. For instance, one worker related a recent occasion when a relative was struggling to cope with their family member. They explained they had stayed with the relative to reassure and comfort them and said, "They gave me a hug and thanked me. It's very satisfying to know you've helped."

Another care worker told us they often cared for people at the end of their lives and were confident in doing

so. They said, "You've got to be gentle. We're very careful, making sure the person is repositioned and kept comfortable, and checking for any signs of pressure damage." The manager told us they were mindful of equipping staff to deal sensitively with the families of people with life-limiting conditions. They said they encouraged a debrief for staff following the death of people they had cared for, and supported them where appropriate to visit the family and go to funerals.

People told us that care workers respected their privacy and dignity. Relatives confirmed this, with comments such as, "Definitely", and, "Yes, they always sit in the back room when we are in the sitting room." We saw that care plans also guided staff about how to protect people's dignity during personal care. A commissioner of the service told us, "First Call staff members treat every patient with compassion, dignity and support the patient and family members through the tough and emotional time that is upon them. We have had no reports of them not carrying out their duty of care towards the patients or family members."

All people consulted without exception stated themselves or their relatives were encouraged by their care workers to remain independent. Relatives gave us examples such as, "They ask [family member] how many spoons of a drink they would like", and, "Yes, they get [family member] up so they can walk around."

People's views about their care were sought during spot checks, at care reviews and through satisfaction surveys. Where necessary, relatives acted on behalf of their family members and gave feedback about the service. The manager told us that to date, no-one had needed to use advocacy services to represent their views, though they would support people in arranging this if required.

People and their families were given a good level of information about the service. They were provided with a guide to the service and contact details, including the out of hours telephone number. Care Quality Commission leaflets about what people should expect from care services were also given. A full copy of the needs and risk assessment and care plan was kept in each person's home. The people we spoke with were not always aware of care plans being in place, however relatives who had used the service for a while said that care plans had been agreed and most had been reviewed.

Good

# Is the service responsive?

## Our findings

The people and relatives we talked with told us they had control over, and were able to make choices about, their care and support. People's comments included, "I told them exactly what I wanted and they did it", and, "I just need to ask for something and I get it." Relatives told us, "We work together with the carers. We talk things through together", and, "We have changed things and times, quite a bit in the first few weeks, and they have been very accommodating." Another relative commented, "They ask me before they do anything. We don't like having hair washed on the first call, so they do it at 11am."

The manager and care co-ordinator told us they aimed to provide a flexible service that fitted in with what people and their relatives wanted. For example, facilitating care workers to accompany people to health care appointments and arranging extra time to support a person when their spouse had an appointment. Systems were in place to readily acquire the necessary funding when people's hours of service needed to be increased.

A commissioner of the service told us, "If an existing patient needs an increase in care, First Call are very fast to advise whether they have the capacity to increase the care package and to date this has always been achieved since [manager] joined. We are always notified if a care package needs decreasing to match the patient's needs." The commissioner also said the service had been good at adapting visit times to suit the person's needs or at the request of their family.

The commissioner provided the service with assessments and the manager or care co-ordinator took responsibility for assessing people's needs and risks before a service was offered. Some background information was also obtained including details of social, religious and cultural needs and family involvement. One person received support time that was specifically for the purpose of helping them in meeting their social needs and to access the community.

People had care plans which we saw addressed all of their identified needs. The care plans were personalised to the individual's routines and preferences and described the care that staff would provide at each visit. Care workers completed records of each visit where they reported on the care and support they had delivered and commented on people's well-being. Systems were in place to review each person's care after the first six weeks and thereafter at six monthly intervals. These reviews took place at the person's home and gave them and their family the opportunity to discuss their service and whether the care given remained appropriate in meeting their needs.

Relatives and people using the service told us they felt the service and their care workers focused on people's individual needs. A relative told us, "We were offered a male carer, [family member] wasn't very keen at the time. We all talked about it and they took into account my concerns, so we said we would give it a try. My [family member] took to him and is quite used to him. When personal care is needed the lady carer does it." Another relative said, "They are always considerate and respect that we live here." A third relative said, "We had one carer who didn't like dogs and we didn't want to lock them away. We approached them and they resolved it by changing the carer."

People were given the complaints procedure in the guide to the service. This informed them about the process to be followed if they were ever unhappy with their care or the service they received. All the people we spoke with stated they would feel comfortable raising concerns and complaints if necessary. Some people and relatives told us they had raised concerns in the past. One person said, "I have talked about medication concerns and we sorted them out." Comments received from relatives included, "No need (to complain). Yes, if there was anything untoward", "Not had any need to complain, we talk through any concerns", and, "They will do anything I ask them to do." Only one person said they had raised a complaint. They told us, "When we first started I complained about the missed calls. They are better now."

We saw that any complaints received had been taken seriously and were promptly investigated. The service had also received a number of compliments, praising staff for the care provided. The manager told us they always acknowledged these and ensured the praise was relayed to the relevant care workers. This was confirmed by the care workers we spoke with who told us they appreciated the positive feedback about their work.

Good

# Is the service well-led?

## Our findings

A new manager had been appointed in April 2016 and they had applied to the Care Quality Commission to become the registered manager for the service. The provider told us they were pleased with this appointment and felt the manager was motivational and managing the service professionally.

The manager described being well supported in their role by the provider, the operations manager and the care co-ordinator. Since taking up post, they said they had concentrated on bringing systems, such as staff supervision up to date, identifying training needs and meeting people who used the service. Weekly business meetings and monthly management meetings had started to be held and another care co-ordinator post had been introduced to strengthen the management team. There were plans to further define roles and responsibilities to support the smooth running of the service. The manager told us that any changes made were done in consultation with the provider and backed by clear rationales of benefiting people using the service, staff and other stakeholders.

We asked people if they considered the service to be well managed. Each person who gave an opinion told us it they felt it was. One person said, "Yes it is." Relatives stated, "Yes, it is well managed", and, "Very well managed." People who had had dealings with the manager held them in esteem, with one person telling us, "The manager is brilliant, the lady who organises everything is very good." Relatives were equally positive about the manager and said communication was good. They told us, "We work together", "We have a great rapport. I have rung and they accommodated everything I have asked for", and, "They always let us know what is happening." One person, who had recently left the service, told us, "I was sad to leave and they were sad to see me go." They explained this was due to the service being unable to provide staff on all the days and times they wanted.

A commissioner gave us very positive comments about the management of the service. They told us, "Yes I believe First Call are very professional in meeting the patients' needs as we have no reports from family members or health care professionals stating otherwise. They are a fantastic care agency and I am very proud to use their service."

The staff we talked with spoke highly of the leadership and support they received and described an open and inclusive culture within the service. Their comments included, "I enjoy working for the company. I get a lot of satisfaction and enjoy meeting people when I do reviews and spot checks", "There's good communication and teamwork", "The manager is lovely, really good", "They're really supportive and I can ring them any time. The new manager is fantastic and knows what they're doing", and, "This manager is there for the clients and the staff." One care worker described the management as being very understanding around their pregnancy; carrying out a risk assessment, giving them lighter duties and accommodating time for appointments.

The manager told us about some of the incentives and ways of communicating with staff which had been improved. These included a recent increase in the hourly rate of pay, provision of new uniforms and the introduction of staff newsletters and memos. Meetings with staff were being restarted and the manager was

seeking their opinions on the frequency, timing and venues. Care workers' views had also been sought in a recent survey. The survey findings reflected what staff had told us about good morale, the management of the service and the support they received.

The people and relatives we talked with confirmed they were asked for their views about their care and the service in general, including completing satisfaction surveys. One relative told us, "The agency manager came and asked questions three times in the last year and filled a form in." We saw the latest surveys carried out had demonstrated a good level of satisfaction with the service. Comments recorded included, "Staff are always pleasant and cheerful", and, "Both carers who regularly attend are efficient, polite and friendly."

Other methods were used to monitor the quality of the service in addition to surveys and regular telephone and face-to-face contact with people. Care plans were being reviewed and audits of care records had been started to validate the care that people received. Regular spot checks were conducted which included, where applicable, observing that care workers followed the provider's procedures in relation to health and safety, personal care, moving and handling and completing care records. Any identified areas for development had been followed up to ensure that all staff adhered to good care practice guidance.

Effective on-call arrangements and communication were in place, with a log kept of all contact with, and responses to, staff, people and their families. This showed appropriate action was taken, for example, in organising cover for short notice absence and informing the person being visited of the changes. Daily handovers between the manager and the care co-ordinator were held which included updates about people's welfare and details of any significant events that had occurred outside of office hours.

The manager told us about their vision for developing the service over the coming year. They were meeting with the commissioner of the service to explore the possibility of optional feedback from families of people who had been cared for at the end of their lives. With input from other professionals, they were looking towards putting together a fact sheet for relatives that could help them with the practical arrangements which need to be made following death. The manager also planned to extend training for staff, further personalise care planning, and consolidate the quality of service provision with a view to the service being expanded in the future.

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 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<br><br>The registered person had not ensured the proper and safe management of medicines. |