Bradnet

Bradnet

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

Bradnet provides domiciliary care services to a range of client groups across Bradford. This includes people with learning disabilities, physical disabilities and older people. At the time of the inspection the service was providing personal care to 12 people. The service also provides social inclusion support to a number of other people who use the service. This aspect of the service does not require registration with the Care Quality Commission and is not included within the scope of this inspection.

The inspection took place between the 22 May 2017 and 1 June 2017 and was announced. This meant we gave the provider a short amount of notice that we would be visiting the office in order to ensure a manager was present.

At the last inspection in May 2016 we found the provider had made some improvements since the previous inspection in November 2015 but was still in breach of four regulations of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We rated the service 'requires improvement' overall and in all of the individual domains.

At this inspection we found further improvements had been made to the service. The service had reduced the number of care packages it provided and was able to provide a more person centred service to people. However we found documentation and organisation relating to recruitment and training needed further improvement.

The majority of people were satisfied with the care and support provided by Bradnet and said it met individual needs.

We saw evidence most people received their medicines as prescribed. However the service was in a transitional phase, transferring records to an electronic system. This new system would need fully embedding before we were fully assured that medicines were consistently managed in a safe way. We made a recommendation for the provider to ensure the electronic medicine management system meets the requirements of recognised community medicine management guidance.

People told us they felt safe using Bradnet. Risks to people's health and safety were assessed and clear and person centred risk assessments put in place.

An electronic call monitoring system had recently been implemented which alerted the office if staff were late or did not attend a call. This helped improve the safety of the service and reduced missed calls.

There were enough staff deployed to ensure people received a reliable and timely service. Appropriate recruitment procedures were in place but we saw they were not consistently followed. During the inspection the manager took immediate action to rectify discrepancies we found.

Staff received regular training and support. However it was difficult to track when training expired through the current training system.

The service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). People's consent was gained prior to care and support and people were offered choices around their daily routines.

Where appropriate, people were supported to maintain good nutrition and hydration.

People said staff were kind and caring and treated them well. People were supported by a small group of staff that knew them well. People were introduced to new care workers before care and support was provided. Cultural and spiritual needs were considered.

People said good care was provided by Bradnet. People's care needs were assessed and clear and person centred plans of care put in place. These were subject to regular review with the person. Care records were in the process of being transferred to an electronic system so staff could receive real time updates as people's care and support needs changed.

A system was in place to log, investigate and respond to complaints. Most people said they were very satisfied with the service and had no need to complain.

The registered manager was honest and open with us about the current performance of the organisation and took immediate action to address any shortfalls we identified during the inspection. However issues with training organisation and recruitment which we identified should have been prevented from occurring through the operation of robust systems of quality assurance.

We identified one breach of the Health and Social Care Act (2008) Regulated Activities 2014 Regulations. You can see what action we asked 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 consistently safe.

The service was in transition between paper and electronic medicine records. We found the new electronic system was improving safety and record keeping. However this system would need to be fully embedded before we were assured that medicines were consistently managed in a safe way.

There were enough staff deployed to ensure a safe and reliable service. Safe recruitment procedures were in place; however we saw they were not consistently followed.

People told us they felt safe using the service. Risks to people's health and safety were assessed and detailed plans of care put in place.

Is the service effective?

Good

The service was effective.

People spoke positively about the staff that supported them. Small teams of staff supported each person to improve consistency and continuity. Staff training was mostly kept up-to-date.

People's rights were promoted because the service was acting within the legal framework of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS).

People were supported appropriately to eat and drink.

Is the service caring?

Good

The service was caring.

People spoke positively about staff and said they were kind, caring and treated them well. Good positive relationships had developed between people and staff. People were introduced to any new care workers before they provided support.

Where appropriate, care was planned and delivered to increase

or maintain people's independence.

People were listened to and their choices respected.

Is the service responsive?

Good

The service was responsive.

People's care needs were assessed and detailed plans of care put in place which included information about their likes, dislikes and preferences. People said their care needs were met by the service.

People's care plans were subject to regular review and people's views and opinions were taking into account during review.

A system was in place to log, investigate and respond to complaints in a timely manner.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

People told us the service had improved. There was a new registered manager in place who was open and transparent and committed to continuing to improve people's experiences.

Some systems to assess and monitor training and recruitment procedures required improvement.

People's feedback was sought and used to make positive changes to the service.

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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.

Our inspection took place between 22 May and 1 June 2017 and was announced. The provider was given a short amount of notice because the location provides a domiciliary care service and we needed to be sure management would be present in the office. On the 23 May 2016 we visited the provider's offices. Between 22 May and 1 June 2017 we made phone calls to people, their relatives and staff.

The inspection team consisted of two inspectors 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. The expert used on this occasion had experience of domiciliary care.

Before the inspection we reviewed the information we held about the service. This included looking at information we had received about the service and statutory notifications we had received from the service. We contacted the local authority safeguarding and commissioning departments to get their views on the service. The service had completed a Provider Information Return (PIR) which is a document which tells us about the service, what it does well and improvements it plans to make. We used this to assist in the planning of the inspection.

We visited the Bradnet office on 23 May 2017 and spoke with the registered manager, the provider and two care co-ordinators. We looked at the way people's medicines were managed, looked at elements of four people's care records and viewed other records relating to the management of the service such as call logs, quality assurance audits, staff recruitment files and training records.

Between 22 May and 1 June we spoke on the telephone with three people who use the service, four relatives and six care staff.

Requires Improvement

Is the service safe?

Our findings

People said they felt safe and comfortable in the presence of their care workers. They said they knew staff well and felt comfortable raising any concerns with them or the office. One person said, "I feel quite safe as I know who is coming. It makes me feel safe having my list of who is coming." Another person said, "It helps me and my sister knowing that he is safe with his carers, we know them well they are local men who he has grown up with."

Safeguarding and whistleblowing procedures were in place and they had recently been followed to help ensure people were kept safe. Where concerns had been previously raised about staff we saw disciplinary procedures were followed. Staff had received safeguarding training. Staff including office staff demonstrated a good understanding of how to identify and act on allegations of abuse. However one person told us of an incident which happened in 2016, where it was alleged that a care worker was unpleasant to their relative. The relative said it had not been dealt with appropriately. Although we saw action had been taken and the care worker no longer worked at the company, we saw this had not been referred to the local authority safeguarding unit at the time. The incident occurred before the current registered manager came into post and since then safeguarding procedures had been followed giving us assurance this would not happen again.

Risks to people's health and safety were assessed and risk assessment documents put in place. These covered areas such as mobility, the environment and any medical conditions or risks specific to the individual. These were clear; person centred and subject to regular review. People said the service helped them to remain safe. One person said, "I had a fall when a carer was here, they suggested we make changes to my bedroom to make is safer for me, it's much better now."

People told us that calls were not missed and they received a consistent service. A newly implemented electronic call monitoring system provided a safety net to ensure calls were not missed. If a call was late, this was instantly flagged on the system which then allowed office staff to investigate and ensure the person received a call before they experienced any harm.

An on call system was in place which allowed staff access to management support outside office hours should they need advice. Staff told us they received appropriate support from management in the event of an emergency.

We concluded there were enough staff to ensure people received appropriate care and support. Over the last year, a large number of care packages had been handed back to the local authority and we saw there were enough staff to ensure people received their agreed care and support. Staff said they did not feel pressured into working additional hours and that rota's were realistic and achievable and where applicable, travel time was allocated. People told us they felt there were enough staff to ensure a reliable and timely service. One person said, "I am happy with the times they come, I know roughly when they will arrive." Another person, "They used to let us down a lot but that does not happen anymore." A third person said, "They always come, even when they are off sick they will always send someone." A relative told us, "We have

a set time as he goes to the day centre during the week so they know to come at the time we requested so he can be ready, at weekends they might come a bit earlier or later, it's not a problem." Another person (who received a double up call) said, "They don't always arrive together due to transport but it's not a problem as the first carer will make me a cup of tea and bring it into my bedroom and by the time I have drunk it the other one has arrived."

We saw recruitment and selection procedures were in place to ensure only staff suitable to work in the caring profession were employed. This included ensuring a Disclosure and Barring Service (DBS) check was completed and at least two written references were obtained before new employees started work.

We looked at the recruitment files for the last two staff to be employed and found the recruitment process had not been completed correctly for one person. For example, we saw the recruitment process was started in 2015 but the person had not been actually employed until March 2017. The registered manager acknowledged the initial application form was poorly completed and should have been rejected. There was only one character reference on file even though the registered manager thought the person had worked in care previously and the application form showed the person had some previous employment history. We saw the person had been interviewed on two separate occasions in 2015 and 2016. However, there was no indication gaps in their work history had been explored or any explanation given as to why the recruitment process had taken so long. There was a current DBS check on file. This was discussed with the registered manager who told us the person had initially applied for a job and then decided to withdraw their application. They later contacted the agency again and expressed interest in pursuing a career as a care assistant. The registered manager acknowledged that a new recruitment process should have been started and could give no reasonable explanation as to why this had not happened. The registered manager took immediate action to address this on the day of the inspection, re-interviewing the staff member and obtaining new references. This provided us with assurance this would not occur again.

At the last inspection in May 2016 we found medicines were not managed in a safe and proper way. Although we found improvements had been made, particularly in the last few months, the service was in a transitional phase transferring medicines records to an electronic medication administration recording system. Once fully implemented, the system would flag up immediately if staff had not given people their medicines as prescribed. The registered manager told us the system would be fully implemented in the coming weeks.

Medicines were administered by staff who had received training in medicines management. Although training was in place there were no competency assessments of staff skill to ensure they retained the correct skills. The registered manager agreed to put these in place.

People said they received appropriate support with medicines. One person said, "They will make my breakfast and give me my meds and make sure I have taken them, they will stand over me."

Care records contained a list of the medicines people were prescribed and whether it was "as required," in a dossette box or its individual packaging to aid identification. We found more information could have been recorded about what each medicine was for, particularly when it was an "as required" medicine to aid consistent administration.

We looked at a sample of Medicine Administration Records (MAR) both electronic and paper and saw overall they were appropriately completed. We saw some gaps and inconsistent use of codes on paper copies had previously been used but this was now improving through use of the electronic system. A staff member told us that some staff did not complete paper records properly and they had raised this with management. We

felt assured this was now being addressed through use of the electronic system. Daily records of care also provided clear information on the medicine support provided to people. Where people were prescribed creams we saw body maps were in place describing where to apply and MAR charts were completed showing their administration.

MAR charts were reviewed monthly and we saw evidence action was taken to address any discrepancies or inconsistencies found. Whilst the new electronic system was in being implemented, these records were subject to increased checks to ensure the system was operating as planned.

We did note that where family assisted with the administration of medicines there was no clear agreement in place specifying who was to provide what support to reduce the risk of mis-understandings or errors. This is a requirement in the new National Institute for Care Excellence (NICE) guidance of medicines in the community issued in March 2017.

We recommend the provider consults recognised guidance on medicines to ensure the electronic recording system considers all the required aspects of a safe and proper medicines management system.

People told us staff adhered to appropriate hygiene techniques. One person said, "They always wear gloves and aprons and I have a method of different coloured sponges for different parts of my body and they know how I like that to work."

Good

Is the service effective?

Our findings

People and relatives said staff were well trained and had the required skills to care for them. One person said, "They are well trained they all know how to use the hoist safely." A relative said, "I assume they are well trained as I'm not in the room with him, he always looks clean and well shaved when they finish." Another person described how the service acted appropriately when they had an epileptic seizure and staff knew what to do. People reported care and support staff were good at dealing with behaviours that challenge. One person said,"The carers are good at distracting [relative] if he is not very cooperative, he loves music so they put it on in the car and he likes it to be loud so they turn it up then he smiles, they know it will change his mood."

People said staff knew them well and reported continuity of care workers. For example one person said, "I have a new carer at the moment and she now knows my moods, she has always read the care plan which has everything in it." A relative said, "He's had the same carers for about a year now, he's known them from young they live local so he recognises them." We saw a small group of care workers had been agreed for each person. This ensured people always knew who was coming and staff could develop knowledge relevant to the person.

Staff received training, which overall was kept uptodate. We saw the majority of staff training was provided by an external training agency and was classroom based. This was so that staff could interact with their peers and the trainer could be confident individual staff members had fully understood the course content. We saw all new staff members completed mandatory induction training prior to commencing work. This included training on safeguarding adults and children, moving and handling, medication, health and safety and The Mental Capacity Act 2005 [MCA] and Deprivation of Liberty Safeguards [DoLS]. Staff praised the training and said the training provider was "informative, hands on, and fun."

The registered manager told us staff with no previous experience in the caring profession had previously completed the Care Certificate but the most recently employed staff had not yet done so. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. The manager demonstrated to us the new staff would commence the certificate shortly. The registered manager also told us new staff members always shadowed a more experienced staff member until they felt confident and competent to work alone.

Whilst we found most training was up-to-date, some staff were supporting people with autism without any formal training. The manager told us these people had extensive experience caring for people with autism. They said they would undertake training needs analysis on these people to determine whether further training was necessary.

We saw individual staff training and personal development needs were identified during their formal one to one supervision meetings. Supervision meetings are important as they support staff to carry out their roles effectively, plan for their future professional and personal development and give them the opportunity to discuss areas of concern. The registered manager told all staff would also have an annual appraisal but the

recent focus of streamlining the service had meant they had not had time to carry out annual appraisals in 2017 so far. However, they confirmed these were planned for the near future.

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. In the case of Domiciliary Care applications must be made to the Court of Protection.

The service had not needed to make any applications to the Court of Protection. Overall, we found the service was working within the principles of the MCA and staff had received training in the MCA. We saw evidence people consented to their care and support and where they didn't have capacity relatives were consulted as part of a best interest process. We did identify that some care records required more detail about people's capacity to understand, process and be involved in decision making. The registered manager had recognised this and was in the process of implementing new paperwork.

Care records showed that staff promoted choice with people and respected decisions. One person described how Bradnet respected their right to refuse assistance with care and support, informed the office and returned later to persuade the person to take their medicines in a "firm but caring" manner. The person said they appreciated this level of support which respected their decision but encouraged them to accept the support they needed to keep them safe.

Electronic care records were in the process of being introduced. We spoke with the registered manager about the need to ensure appropriate consent and best interest processes were followed if care records were to be accessed remotely by relatives or other professionals.

People reported they received the right support to eat and drink. One person said, "I decide what I want to eat and they will put it in the microwave it's not a problem it gets delivered weekly and I just put aside each day what I want to eat, if I can't manage to make a sandwich they will do it for me anything I want." A relative said, "I prepare his breakfast they will feed him, if I haven't prepared it they will do it." People's care and support arrangements with regards to food, including their likes and dislikes were recorded within their care plans. Daily care records provided evidence people were offered food and drink in line with their plans of care.

Care records showed people's healthcare needs had been assessed and appropriate plans of care put in place. People said healthcare needs were met. One person said the staff were particularly good at interpreting their body language to recognise when they were deteriorating. We saw the service liaised with a range of health professionals including GP's and district nurses if people's healthcare needs changed. The registered manager was currently working with health professionals to ensure that the new electronic care recording system did not negatively affect the accessibility of key information on people's needs. This was work in progress but interim measures had been put in place to ensure people's safety.

Good

Is the service caring?

Our findings

People and relatives told us care staff were kind and compassionate and treated them well. One person said, "If I am down they cheer me up. I am quite satisfied with the care I receive, they are all delightful people." A relative said, "He knows what time they come for him he gets his shoes on and waits by the window and he is smiling so I know he enjoys their company." Another relative said, "They seem kind and caring, I hear them chatting to him." Staff we spoke with demonstrated good caring values and a dedication to providing people with the care and support that met people's choices and preferences.

People said staff treated them with dignity and respect and respected their privacy. One person said, "Bed baths are done with so much dignity, to change my pad they will ask me to lay on my side away from them, it's more respectful." Another person said, "They are respectful they will give me a sponge and I do the private bits." A relative said, "They will always shut the door to respect his privacy."

People and relatives reported good positive relationships had developed between people and staff. We saw a small group of care workers was assigned to each person to help develop these relationships. One person said, "They are my friends not just my carers and if I'm out and about in the community and I see one of them they will always acknowledge me." A relative said, "We get mostly the same carers as he does not like change, he likes a male and they respect that, occasionally he will have a female if his main carer is off sick that's ok, if it's a new carer they will bring them first to introduce them." Another relative said, "They have to assess his moods day to day but the rapport they have means they know him well and know how to deal with him."

Information on people's likes, dislikes and life histories was present within their care and support plans. This helped staff to better understand the people they were supporting. Thought went into matching care workers with people who had mutual interests to assist the development of good relationships. The office was now better organised so information could be communicated to people about any changes to their care workers. People said they usually knew who was coming to support them and they got introduced to new care workers first. One person said, "I know who is coming and if it's someone new I get a visit first. I have a core of around four carers during the week, it might vary at weekends but they will introduce anyone new."

People's communication needs were assessed and contained within care and support plans. People reported staff communicated effectively. One person described how they had a picture book which staff used with them to communicate their needs such as "cup of tea, cigarette, bed, and please change me I am wet." Another person described how they had a bespoke method of communicating when they felt unwell and this was well understood by the staff supporting them.

People said where appropriate independence was promoted. One relative said, "Depending on his mood they will encourage him to do things for himself." We saw care plans were developed encouraging people to do tasks for themselves such as washing part of their body to help maintain independence.

People and relatives said they felt listened to by the service. Daily records of care showed people were given choices over activities, daily routines and food and showed those choices were respected. Staff recognised the importance of giving people choices were able to give examples of how they offered people choices on a daily basis. There were various formal and informal mechanisms for people to voice their opinions, including telephone interviews, spot checks and surveys.

Good

Is the service responsive?

Our findings

At the last inspection we found care was not always appropriate and staff did not always spend the right amount of time with people. At this inspection, we found improvements had been made.

People said they received appropriate care that met individual needs. One relative said, "The quality of care so far has been very good." Another relative said, "Yes I am happy with the quality of care that he gets, it does meet his needs." A third relative said, "The main two he has at the moment seem to know him well and meet his needs from what I see anyway." People said personal care needs were met by the service. One person said, "They give me a good wash down, they are very thorough." A relative said, "He likes to shower every day which they respect and do."

People reported all required tasks were completed; staff arrived on time and stayed for the required amount of time. This was confirmed by the daily records of care and support we reviewed which showed consistency from day to day. This was now being monitored through the electronic call monitoring system.

The registered manager told us when a person was initially referred to the agency they were always visited by a care coordinator before a service started. During this visit a full assessment of their needs was carried out. We were told the process took into account any cultural, religious, physical or complex needs the person had. The registered manager confirmed that they would not take on a care package unless they were absolutely certain they could meet the person's needs. People confirmed this process took place. One person said, "At the beginning they did an assessment and spoke to me in great deal, they got extra equipment". We saw people were given an information pack which outlined the care, support and facilities provided by the agency which helped them to make an informed decision about whether or not they could meet their needs.

We saw pre-assessments were used to populate detailed and person centred care plans which contained information on how to meet people's needs in areas such as mobility and nutrition. These were subject to regular review. People confirmed they had care plans in place which were subject to review. One person said, "I had a meeting with the manageress recently and updated my care plan." We saw the service was in the process of introducing electronic care records. It would also allow staff to access people's care plan and other documentation using mobile phones, tablets or computers. This meant that any changes would be immediately visible. a discussion was held with the registered manager about the need to ensure people who used the service, their relatives and other healthcare professional were fully involved and aware of the new system.

People's social and spiritual needs were considered in care planning and appropriate plans were put in place to meet these needs. One person said, "If it (care tasks) doesn't take the full time they will stay and chat to me." A relative said, "They take him out into the community in the evenings as well, maybe for a meal or a walk or a drive, he likes the car." The registered manager told us staff were always introduced to people before they started to provide care and support and wherever possible staff were matched to people in terms of age, gender, personal experience and lifestyle. Some of the staff working at the service were bi-

lingual and efforts were taken to pair appropriately dependant on the culture and language of people receiving the service.

There were various mechanisms for people to raise complaints or opinions, including regular reviews, telephone checks and spot checks. Most people we spoke with were highly satisfied with the service and had no complaints. One person said, "I have no complaints but I would know what to do if I did." A relative said, "I have had concerns in the past about the attitude of a couple of carers who 'like to give their two penny worth' so I complained and he does not see them anymore." However another person said that they had made a complaint about staff behaviour in 2016. Although we saw action had been taken to prevent a re-occurrence we concluded further communication was required with the person to discuss and alleviate their remaining concerns.

The registered manager told us they had a proactive approach to managing complaints and was always available to talk to people and deal with any concerns as soon as they arose. We saw there was a complaints procedure in place and the registered manager told us the procedure could be made available in different formats and languages if necessary. We saw complaints had been responded to within a timely manner.

Requires Improvement

Is the service well-led?

Our findings

We found most required notifications had been submitted to the Care Quality Commission (CQC). However we found the registered manager had dealt with a safeguarding incident but not notified the CQC until they had completed the investigation. We reminded the registered manager of their responsibility to inform CQC of any safeguarding incidents at the start and not the end of the investigation process. The registered manager acknowledged their mistake and confirmed they would do so in the future.

At the last inspection in May 2016 we issued warning notices with regards to staff training and governance. Although we found improvements had been made to areas such as medicine management, some auditing processes and elements of training we were concerned that training records were not well organised meaning it was difficult to establish if staff training was up-to-date or had expired. We found training for individual staff members was recorded on three separate documents which had to be cross referenced to establish what training they had completed. Due to this confusion, this meant there was a risk staff could be allocated to calls without receiving the required training. The registered manager confirmed the agency was introducing an electronic rota system which when fully implemented would not allow staff to be matched with people who used the service unless they had received the training required to meet their needs. We also found one staff file demonstrated inappropriate recruitment procedures. During the inspection the manager took immediate action to address these areas of concern; however this should have been prevented from occurring through the operation of robust systems of quality assurance.

Although people's feedback was sought through questionnaires, these had not been recently collated to look for overall themes and trends. We also identified because the provider was in the transition between systems, information on incidents, accidents and missed calls had not been effectively audited over the last few months. We were confident this would be addressed now the new system was in place

This was a breach of Regulation 17 of the Health and Social Care Act 2008 Regulated Activities 2014 Regulations.

A registered manager had been in post since September 2016. We found they were open and honest with us about the current quality of the service and acknowledged the areas that required improvement. We were confident the remaining improvements would be made to the service. Since the last inspection, the service had been streamlined with a reduction in senior managers This reduced the overlap of responsibilities and led to more clarity over individual roles. This was reflected in comments we received from the care coordinators and staff. One staff member told us, "[It is] a lot better, less hierarchy, roles. Consistent staff now." Another staff member said, "[I am a] lot happier, got a good staff team." A third staff member said, "Management are spot on to be honest, any issues are resolved straight away." Staff told us they were confident the service had improved over recent years and they thought it provided good quality care.

Most people spoke positively about the overall quality of the service. People praised the manager and the way the office was run. One person said, "Yes I know the manager she is approachable." Another person said, "If I need to change something they are helpful in the office" and "I think they have improved over the

last year they seem to continue to improve." A third person said, "Even if I call to ask a question no matter how minor they don't mind, like today after the carer left I couldn't find my deodorant so I called the office and they contacted the carer who called me and said to look in the bathroom." A relative said, "I rang this morning to ask for a meeting as I want to discuss a couple of things, they said they will call me back which I'm confident that they will." Another relative said, "[I] know them in the office they are charming people." A third relative said, "They are always helpful in the office, if I call and leave a voicemail they will get back to me." However, one relative said, "I do not feel confident in Bradnet, I am not happy." We raised this issue with the manager to allow them to address with the person.

Quality assurance systems were in place and people's feedback was sought and used to make changes to service. We saw that regular service user reviews, quality visits to people's homes and spot checks on staff practice took place. These asked people for their views on the service, observed staff practice to ensure it was appropriate and checked documentation. We saw evidence these were effective in identifying and rectifying issues such as medication discrepancies and negative feedback.

We saw the frequency of the quality assurance visits such as spot checks had recently been increased as care co-ordinators now had 12 hours a week dedicated time to carry out these checks.

The service had recently implemented an electronic call monitoring system. This recorded in real time, staff arrival, departure and the completion of care tasks including medication. Although the system was only in its early days, it provided a key safety net and ensured the service was able to respond quickly to any risks. Staff praised the electronic system and said it made It easier to record key support information. Audit and checking procedures around the new system were being developed. In some cases paper records were still used such as MAR charts and daily records and these were subject to regular audits and checks. We saw these checks were effective in identifying issues.

The registered manager told us staff forum meeting were usually held on a six monthly basis but due to restructuring the business they had not been held for some time. However, they told us the agency now only had a relatively small staff teams and they kept staff informed of any changes to policies and procedures or work practices. The registered manager told us they were trying to promote an open door policy to encourage staff to come into the office and have a drink and a chat as an additional support mechanism. A staff member we spoke with said they found the office friendly and supportive and felt encouraged to drop into the office to see members of the management team.

In addition, the registered manager told us they had sent out a staff survey questionnaire in April 2017 but had not yet had time to collate the information. They told us once collated any concerns identified would be addressed and the information gathered would be used to improve service delivery.

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 17 HSCA RA Regulations 2014 Good governance (1) Systems and processes were not established to ensure compliance with the regulations in this part (2a) Systems to assess, monitor and improve the service were not sufficiently robust. (2e) The service had not acted on feedback of relevant persons.