Bridge Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	Good
Is the service effective?	Requires Improvement
Is the service caring?	Good
Is the service responsive?	Good
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

This inspection took place on 21 September 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location office when we visited.

Bridge Care Services is a domiciliary care agency that provides support to people who live in their own home, both older people and some younger adults with disabilities. They provide a service throughout the Stockport area to people who have a service commissioned via the local authority and to people who are privately funded. The office is situated in the centre of Marple. At the time of our inspection 122 people were receiving support from the service.

The service is required to have a registered manager, and at the time of our inspection there was a registered manager in post. 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.

The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse, and staff we spoke with understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns.

We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm. There were some gaps in paper copies of risk assessments held in the office, but these were available on the computer system.

The provider had a safe system for the recruitment of staff and was taking appropriate steps to ensure the suitability of workers.

People that we spoke with told us that staff usually arrived on time, or within the 15 minute timeframe allowed for the start of the care visit. On occasions when there was staff sickness other care staff covered their care visits. People told us that on the rare occasions staff were running late, or there was a problem, someone from the office would usually phone them to let them know.

Where staff supported people with their medication, we found that this was accurately recorded on medication administration records. Staff had received training in administering medication and the registered provider periodically observed staff competency. This showed that there were systems in place to ensure people received their medication safely.

Staff completed a range of training to help them carry out their roles effectively, and this was refreshed annually. Action was being taken to ensure staff who were overdue their refresher training completed this.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as district nurses, GPs and the anticoagulant clinic. People were also supported with their nutritional needs, where this was part of their care plan.

People told us that the staff who supported them were caring and that they felt involved in decision making about their care. People also reported that they felt their privacy and dignity were respected. Staff we spoke with demonstrated a caring and empathic approach towards the people they supported.

Everybody who used the service had a care plan, which contained information about people's needs and routines. Staff also demonstrated an understanding of people's individual needs and preferences. However, some people's annual care review was overdue, which meant that the registered provider had not consistently ensured that all people's care plan was up to date.

There was a complaints procedure in place and the majority of people who used the service told us they knew how they could raise a complaint if they needed to, and that they would feel comfortable doing so. People and staff told us that the registered manager and staff in the office were approachable and helpful.

Not all staff had received regular supervision, in line with the registered provider's policy. This was a breach of legal requirements.

There was a quality assurance system in place, which included service user satisfaction surveys, staff observations and care reviews. This enabled the registered manager to identify some issues and measure the delivery of care. The majority of people who used the service expressed a high level of satisfaction about the service they received. However, we found a number of issues that the quality assurance processes had failed to address. For instance, record keeping at the office was inconsistent, making some information difficult to locate; policies and procedures were overdue their annual review and not all staff had received regular supervision. Collectively these issues showed that the quality assurance system was not sufficiently robust in leading to improvement and identifying that record keeping was poor. This was a breach of legal requirements.

You can see what action we told the provider to take in respect of these breaches at the back of the full version of this 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?

Good

The service was safe.

There were systems in place to protect people from avoidable harm. Staff had been trained in safeguarding vulnerable adults and knew how to report any concerns.

Robust recruitment processes and appropriate checks were completed before staff started work.

There were systems in place to ensure that people received their medication safely.

Is the service effective?

Requires Improvement

The service was not always effective.

Staff received an induction and regular refresher training. Some staff's refresher training was overdue and not all staff had regularly had formal supervision meetings.

Staff were able to demonstrate an understanding of the importance of gaining consent before providing care to someone.

People were supported with their nutritional needs where this was required. They also had access to healthcare services.

Is the service caring?

Good

The service was caring.

People told us that staff were kind and they had positive caring relationships with the staff that supported them.

People we spoke with felt that staff involved them in decisions about their care, and that staff respected their privacy and dignity.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place to enable staff to provide personalised care. Staff demonstrated an understanding of people's individual needs and preferences.

There were systems in place to manage and respond to complaints and concerns.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Care staff were positive about the culture of the organisation and the support they received from the registered manager and staff at the office.

Quality assurance systems were not always effective because they had not addressed issues we identified in our inspection.

Bridge Care Services Limited

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 21 September 2016 and was announced. The provider was given 24 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection team consisted of two adult social care inspectors.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur.

We did not ask this service to send us a provider information return (PIR) before the inspection. The PIR is a document that the registered provider can use to record key information about the service, what they do well and what improvements they plan to make.

As part of this inspection we spoke with 12 people who used the service, three relatives of people who used the service, two care coordinators, three care workers, the deputy manager and the registered manager. We visited the agency office and looked at five people's care records, six care worker recruitment and training files and a selection of records used to monitor the quality of the service. The registered provider sent us some additional information the day after our inspection.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe with the staff and the support provided by the service. People's comments included, "I always feel safe with the carers that visit," "Very much so [feel safe]," "Yes I am comfortable with them," and "I feel perfectly safe with them."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. All staff received training in safeguarding vulnerable adults from abuse as part of their induction training, then refresher training thereafter. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Staff told us they would report anything straight away to their line manager. The safeguarding records we looked at recorded when a referral had been made to the local authority and what actions had been taken. The registered provider also had a whistleblowing policy, which enabled staff to raise concerns. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

Risk assessments were developed in relation to people's individual needs. These included moving and handling assessments, medication and household safety risks. The format of support plans and risk assessments had changed the previous year. We found that the new format also prompted staff to consider any risk and control measures in each area of support provided, such as personal care and nutrition. We found that the risk assessments held on file in the office did not all appear to have been reviewed regularly in line with the registered provider's policy. On exploring this further, and discussing this with the registered manager, it became apparent that on occasions the paper copy of the risk assessments in people's care files in the office had not been updated in line with the up to date version held on the computer and in the person's own home. The registered manager agreed to review the files to ensure the paper copy of the care record in the office was consistent with the up to date version held on the computer.

We saw that records of any accidents or incidents were stored in individual files, and a copy passed on to the office, in order to ensure appropriate action had been taken in response to any incidents. An accident book was held at the office and this also showed that the registered manager had reviewed any accidents.

The registered provider had a business continuity plan. This detailed how the provider would respond to minimise the impact to people using the service, in the event of an emergency such as the loss of electricity, water, IT and telephones at the service.

The registered provider had a safe system for the recruitment of staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references and identification checks. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The registered manager told us that where historical records had not been retained for some long standing staff members, they were submitting DBS checks again to ensure

there had been no changes. The recruitment records we viewed showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We talked to the registered manager, care staff and people who used the service about whether there were sufficient staff available to meet the needs of people who used the service. The registered provider completed an initial assessment of people's needs, prior to providing support to them, and this enabled them to determine with the person the frequency and duration of care visits required. Staff rotas were planned around care packages organised in 'runs' on a geographical basis. Where there was any sickness or unplanned absences other care staff were asked to stand in. We were told that there had been a particularly busy period over the summer holiday period, due to annual leave and some staff sickness, so care staff had picked up additional care visits in order to ensure people's care was provided. The registered provider also had an on-going recruitment drive in order to recruit additional staff.

The registered provider used an electronic call monitoring system, so that they could identify if a care visit was late, without having to rely on staff calling in to update them. The system did not automatically alert the office when a carer had not logged in for a call as scheduled on the rota, however, office staff could manually log in to check this. They were also able to use this system to monitor the number of care visits that were provided on time, according to the schedules, and the duration of visits.

People we spoke with who used the service told us that staff were almost always on time, or within the fifteen minute timeframe allowed for the start of the call visit. They also told us that staff stayed the right length of time. One person told us, "Occasionally if there have been new carers I've had to ring to find out when they are coming." However, all the other people we spoke with indicated that staff from the office let them know if care staff were going to be late. Comments included, "They are almost always on time. On rare occasions they run late but they usually let you know," "They are very reliable," and "They are usually on time. On the odd days that they may be late they'll ring us to say they are running behind." Another told us, "They always come when I expect them to. If there are any problems they would ring me. Very occasionally, if there are problems they may need to call and say they will be late."

One person told us, "They always stay the full length of time and if anything they would stay a bit longer if they needed to. I get a rota every week, telling me who will be coming each day. We used to get continuity every day, but not so much these days, although I appreciate it is not always possible to have the same person every time. But we do get a reasonable degree of consistency and I am comfortable with all of the carers that come."

There was an 'on-call' system; staff or people could call the office if there were any problems, or could call for support 'out of hours' if there was an urgent issue outside normal office hours. Staff spoke positively about the support and communication they received from the office, including, "They are very good in the office. There are no issues with communication. They are very prompt on the phone. I can always get through to someone, I have never been let down."

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers of staff to fulfil the planned care visits and meet people's needs.

The registered provider had a medication policy in place, which was available to all staff. Staff had received training in medication management and their competency was assessed before supporting people with their medication. Care coordinators checked medication administration records (MARs) when they were returned to the office, to identify any gaps or issues. There were, however, no formally recorded audits of medication documentation and practice and we discussed this with the registered manager, who agreed to

review the way they recorded their checks on medication.

People's individual care files contained details of any support required with medication, including who was responsible for ordering medication and any specific requirements. Where the registered provider shared responsibility for medication with anyone other than care staff, such as family members, there was information in the care file to clarify the role of each party. We looked at a selection of medication administration records, and these were appropriately completed.

This showed us that there were systems in place to ensure people received their medication safely.

Requires Improvement

Is the service effective?

Our findings

We asked people who used the service if staff had the right skills and experience to do the job; the majority of people we spoke with told us they did. One person felt there was some inconsistency because new staff who had been providing cover for their usual care staff over the summer holiday period were not as experienced or skilled at specific care tasks. Another person commented that staff were, "Mostly capable, but some better than others [at tasks such as preparing meals]." However, the other people we spoke with commented positively about the staff, including, "I am happy with my carers," and "They seem to have the right skills. They tend to learn on the job, but if they are new they would come with someone else first." A relative told us, "The carers are all very different; with difference skills and personalities, but they are all friendly and do their job!"

We saw that all staff completed an induction when they started in post. Training covered as part of the induction included medication, moving and handling, safeguarding, first aid, food hygiene, health and safety and fire awareness. Staff also spent time reading policies and procedures and care plans. Staff confirmed to us that they shadowed other staff when they were new in post until they were assessed as competent to work independently.

The registered provider required staff to complete regular refresher training, in order to keep their knowledge up to date. The registered provider was able to monitor when staff were due to complete refresher training, as records were held electronically. Training records showed that some staff were overdue their routine refresher training. This included gaps in refresher training on safeguarding, first aid, food hygiene, medication and moving and handling. We saw that action was being taken to address this; some training was booked and reminders had been sent to staff to complete overdue on-line training in first aid and food hygiene. Questionnaires had also been sent for staff to complete regarding medication and moving and handling, in order to assess if staff required additional training in these areas.

We saw some evidence of staff supervision and staff information memos; both covering a range of appropriate topics. Observations of practice were completed at least once a year in order to monitor care delivery. However, records showed us that not all staff had received regular formal supervision since the start of the year, and eleven staff had not had formal supervision for more than six months. The registered provider's policy was for staff to meet formally on a one to one basis at least every three months. When we spoke with the registered manager about this, they told us that due to a particularly busy period they had sometimes had to postpone supervision meetings in order to prioritise care calls.

This was a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, Staffing.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the registered provider was working within the principles of the MCA. We saw evidence that people had been involved in decisions about their care and most people had signed to consent to their care plan. We found, however, one care file where family had signed consent to the care plan on the person's behalf, but it was not clear in what capacity they were signing the document. There was no information about the person's capacity to make their own decision about their care, and the registered provider did not have information about whether the relative had Lasting Power of Attorney (LPA) for health and welfare. Therefore it was not possible to ascertain whether they had the appropriate authorisation to provide consent on the person's behalf. The registered manager told us they would address this, and showed us the new care plan format the service now used which prompted staff to check this.

Staff had completed some training on the MCA, as part of a safeguarding vulnerable adults course. They were able to demonstrate an understanding of the importance of gaining consent before providing care to someone.

We looked at the support people received with their nutritional needs. Some people who used the service did not require support in this area, because they were able to prepare their own meals and drinks independently and did not require mealtime calls. However, other people we spoke with received regular support from the service with their meals. Care plans contained a section about the person's nutrition and hydration needs, food and drink preferences and the specific support required from staff. We were shown food and fluid intake monitoring charts, which we were told were used when people were at specific nutritional risk and required their food and fluid monitoring.

People that received support with meals told us they were satisfied with the support provided. Comments included, "They make sandwiches and meals for me. They put me a ready meal in if I ask them to. I'm happy with the meals they prepare for me" and "They help me with meals. They prepare the vegetables and I tend to do the rest because I'm able to do that myself." Another told us, "I tell them what I want to eat. You get new carers who are less experienced [at cooking], but they are mostly good."

People were supported to maintain good health and access healthcare services. We saw evidence in care files and in the communication records held on the registered provider's computer system of contact with other healthcare services, such as district nurses and GPs. For instance, we saw that staff had contacted a district nurse for one person who had a sore area on their heel, in order to seek guidance on preventing this potentially developing into a pressure sore. The registered provider also had regular communication with the anti-coagulant clinic, to ensure people who required warfarin (blood thinning medication) received the correct dosage of medication. People we spoke with told us that if they felt unwell and needed support to contact the GP, they would be able to ask care staff to do this for them. One person told us, "I am certain they would help with this if needed. One time they helped me when I was unwell and they rang the office and sorted it. They seem responsive in this regard."

Good

Is the service caring?

Our findings

We asked people who used the service if staff were caring in their manner and approach; the feedback we received was positive. People told us, "They are caring," "They aren't just my carers, they are my friends," "They are definitely kind and caring," and "They are nice. We've got used to each other and jog along quite happily." One person told us, "They are lovely... I do get different ones sometimes, but that's okay because they are all very nice and I look forward to meeting them. I know who is coming because I get a rota." Other comments included, "Some staff are more skilled at picking up on things than others but they are generally all kind" and "The carers are kind; I enjoy their company because I get very lonely. We can talk and do things; we have a natter while they do their jobs."

Staff we spoke with demonstrated a caring and empathic approach towards the people they supported, and enjoyed their work. One told us, "I get a lot of satisfaction. For instance, I've seen a 92 year old lady this morning and it's really nice to think that I've supported her to bathe and meet her personal care needs so that she can live independently. We've had a chat this morning and I know she enjoys the company, and I get a lot of enjoyment and satisfaction from this too."

People had choice and control about their care and felt their views were acted on. One person told us staff "Definitely" involved them in decisions and "They would always respect your choices and decisions." Another told us, "I can change things if I want. They review my support about once a year, but you're free to say in the meantime if you want any changes. For instance, I ring them when I want to change my call times." Others also confirmed that staff involved them in decisions and respected their choices.

We saw from care files that people's independence was promoted wherever possible. People we spoke with confirmed to us that they continued to do as much for themselves as they were able to, and that staff just gave them support where they required it.

People told us that staff maintained their privacy and dignity, especially when providing support with personal care, such as bathing and washing. One person told us, "I have no problems with this; they always maintain my dignity" and "Yes, they respect my privacy and they keep me covered." A relative told us, "They have a laugh with [my relative] and put them at their ease. This is important, because it could be awkward for them, getting personal care from another woman, but they make it fine and are really good at putting them at their ease. They always cover [Name] with a towel and respect their dignity."

Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. They gave examples such as ensuring doors and curtains were closed when providing personal care, ensuring people were covered and not rushing people. One staff member told us, "I believe staff are consistent about this [respecting privacy and dignity], from what I have observed during my induction and when working with others. For instance, when I was shadowing another staff member, one person did not want me in the room whilst they were receiving personal care from the other carer. So that carer recognised this and responded straightaway, by asking me to go and do another task like putting the kettle on, so that they could support the person with some privacy." Another staff

member told us, "When you're going into someone else's home and personal space you have to respect this. You explain what you're going to do and discuss between you how you'll do this. People have their own ideas, so you would discuss before going into the bathroom how the person wants their support and whatever makes them comfortable. You observe their privacy by waiting outside if they want to use the toilet before their shower for instance, and always knock on the door before going in to the bathroom."

Discussion with staff indicated that there were no people using the service that had any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people using the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone that used the service was discriminated against and no one told us anything to contradict this. Staff were aware of people they supported who attended church but told us they did not require support from the service to do this. The registered provider had an equality and diversity policy and a privacy, dignity and human rights policy that were shared with staff.

Some people who used the service were not able to communicate verbally and staff were able to explain the other communication methods those people used to express their needs and preferences. For instance, staff described how they used a communication book with one person, which had key words the person could point to. Staff were also knowledgeable about the gestures and non-verbal communication this person used to express themselves, and how to reassure them when they were becoming frustrated.

Good

Is the service responsive?

Our findings

All of the people who used the service had a care plan, which they had been involved in developing. People told us, "I have a care plan; I was involved at the beginning in writing this and am involved in the reviews of my support" and "I had someone come to do an assessment before they started supporting me, and I have a book [care plan] at my home. Carers write in it before they leave." One relative told us, "[Name of coordinator] visited when we first started getting the care package. They did an in-depth interview with us about [my relative's] needs and developed the care plan. We have reviewed this annually since." Another relative said, "They came to assess [my relative] before providing support and we talked to them about what [Name] needed."

The registered provider completed an initial assessment of people's needs, prior to supporting them. This included gathering information about people's personal circumstances and important contacts, their medical history, and their needs in relation to medication, personal care, moving and handling, and nutrition and hydration. The assessment formed the basis of the care plan, which was developed when people started to use the service.

Care plans included information about people's routines and the support required at each care visit. There was also information about people's needs and individual preferences. We found that care records in the office were not consistently filed and a paper copy of the most recent support plan and review documentation was not always held in each person's care file. On exploring this further with the registered manager it was apparent that documentation held on the computer had not always been printed and transferred into the hard copy files. At the end of our inspection the registered manager provided us with evidence that care packages had been reviewed and care plans updated accordingly, but improvements were required in relation to the maintenance of records and we have reported further on this in the 'Is this service well-led?' section of this report. The review of some people's care packages was also overdue, and the registered provider was taking action to address this.

Despite gaps in the paper records held on file, there was other evidence that showed us that the service was responsive to people's needs. The registered provider recorded any communication with people on their computer system, along with contact with other professionals and family involved in their care. Daily communication logs, held in people's own homes, were completed by staff with information about the support provided during each visit. These daily communication logs and medication records were returned to the office, which enabled the care coordinators in the office to identify any issues and check the support provided was in accordance with people's care plans. Any issues or concerns identified by staff on their care visits were also recorded on the communication log and reported to staff in the office, so that they could respond appropriately. The office staff also communicated to care staff via text message to promptly update them of any key information or changes to care plans. They kept a log at the office to record which staff had been notified, so that they could ensure everyone who required the information had received it. People confirmed to us that staff always wrote in their file when they had completed the visit.

The records we viewed, and feedback from people and relatives, showed us that staff were person centred

in their approach and flexible according to people's needs. People told us, "They are very obliging" and "I can change things if I want." One relative told us, "They are very flexible and try and accommodate extra call visits if we request them, like when I am going to be away… We also managed to work the care package very flexibly last year when [my relative] was unwell, so that I provided some of the support with them. It saved them having to go into hospital." Another relative told us, "I didn't know what to do when [my relative] was in hospital [prior to receiving a care package] as we were told they couldn't leave until they had a care package in place. Thankfully Bridge Care said they'd come and assess [my relative] straightaway. We were so thankful for that. I don't know what I would have done without them." They continued, "[My relative] has a care file and staff always fill it in before they leave. We've very happy with the service." We saw comments in satisfaction surveys, such as 'There was a weekend where my [relative] was ill. The carer reported it to the office staff who worked hard to get the GP involved. They also contacted us to keep us informed. It is wonderful and reassuring to know that you all care about my [relative]."

There was a complaints procedure in place and a system to record and respond to complaints. Records showed that two complaints had been received in 2015 and two complaints in 2016. These records showed that the provider had responded promptly to try and resolve the issue and respond to the complainant.

The majority of people we spoke with told us they knew how to raise a complaint and would feel very comfortable doing so. One person we spoke with said they felt "A bit funny about ringing them [the office]" because they had previously raised an issue and were not confident that their concern had been fully recognised. However, other people we spoke with said they would be very confident to raise a concern if they had any, and comments included, "I'd be very happy to tell them if something was wrong because everyone is nice, including the girls in the office," "I'd ring the office if I had any problems," "I've never needed to [raise a complaint], but I suppose I'd just call the office. I'm sure they'd help," and "I'd be able to raise a complaint. I've not needed to though really." A relative told us, "I would feel comfortable raising any concerns. The girl we've been dealing with in the office has been brilliant from day one." There was also an opportunity to raise any issues at the person's annual care review.

This showed us that concerns and complaints were encouraged and that there was a system in place to respond to complaints.

Requires Improvement

Is the service well-led?

Our findings

The service had a registered manager in post. The registered manager understood their role and responsibilities. There was also a deputy manager at the service. The deputy manager, alongside two other care-coordinators, organised the co-ordination of the care packages and rotas for each of the three geographical areas they covered. They also conducted observations of staff to monitor the quality of service provided.

People told us the registered manager and staff in the office were approachable. Staff told us, "They are very good in the office; they give you back up. I think the service is well-led. I find every member of staff in the office very helpful" and "It's definitely well-led; we communicate quite well and help each other out." Other staff described the management of the service as, "Really friendly and helpful" and told us, "On the whole everything runs okay; they're a good team." One person who used the service told us they had heard one staff member complaining to another, within their presence, about having to cover care visits in other areas, which was not professional and they felt was indicative of poor staff morale. However, staff we spoke with told us that despite there having been a busy spell recently, due to staff sickness, staff morale was good and that they did not feel under pressure to take on additional work if they did not want to.

Staff told us that the values of the organisation were about "Putting clients and staff as a priority. They emphasise confidentiality, privacy, respect and courtesy; all the things you would expect" and "Promoting independence in the home and ensuring people's safety."

This showed us that the service promoted a positive and person-centred culture.

Staff did not always receive regular supervision in line with the provider's policy. Care staff received regular written staff information memos but only had meetings periodically. We looked at a selection of weekly care staff memos, and saw these gave a range of detailed instructions, reminders and updates to staff in relation to people's care packages. Separate weekly staff memos were produced for staff in each of the three geographical areas the service covered. Office staff meetings were held regularly, and minutes of these showed that topics discussed included staff recruitment, training, the rota system and deployment of staff.

The registered provider conducted annual service user satisfaction surveys, and produced a report of the findings. We saw copies of these reports, including findings of the 2015/16 survey which was sent out in February 2016. 71 surveys were completed and returned, which equated to 63% of the people who used the service at that time. Questions were asked about a variety of subjects, including whether staff arrived on time, whether people were supported by regular staff and were kept informed of changes. Other questions were about whether staff were polite and approachable, treated them with dignity and respect, whether people had choice and control and were involved in their care planning. The results of the survey were largely very positive and 67 out of the 71 responses indicated that they would recommend the service. The remaining four respondents left this recommendation question blank. Quotes in surveys included 'I think your service is fab' and 'It is superb.' We saw that notes had been made on all survey responses where any action was required, indicating that the registered provider had acted on comments in the surveys. The

report on the overall survey findings was also shared with people, and included the service's response and action taken.

The quality assurance system in place included these user satisfaction surveys, staff observations and care reviews. This system enabled the registered manager to identify some issues and measure the delivery of care. The majority of people who used the service expressed a high level of satisfaction about the service they received. However, we found a number of issues that the quality assurance processes had failed to address, such as the record keeping at the office which was inconsistent and made some information difficult to locate. Some documentation was not provided to us until the day after our inspection. Policies and procedures were overdue their annual review and not all staff had received regular supervision. Whilst medication records were checked, these checks were not formally recorded so it was difficult to evidence action taken in this area. Some people's annual care reviews were also overdue, and care plans were not routinely audited to check their quality. Collectively these showed that the quality assurance system was not sufficiently robust in leading to improvement and that record keeping was poor.

This was a breach of Regulation 17(2)(a)(c) of the Health and Social Care Act 2008 (Regulated Activity) Regulations 2014, Good Governance.

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 The registered provider had failed to keep accurate and well maintained records in relation to the care of each service user and the running of the service. Quality assurance systems did not identify the issues with record keeping, in order to improve the quality and safety of the services provided. 17(2)(a)(c)

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The registered provider had failed to provide appropriate staff supervision. 18(2)(a)