Core Outreach and Care Services Uk Ltd

479 Green Lanes

Inspection report

Core Outreach & Care Services UK Limited
479 Green Lanes
London
N13 4BS

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09 December 2016

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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

This inspection took place on 8 and 9 December 2016 and was announced. We gave the provider 48 hours' notice that we would be visiting to ensure that the registered manager would be available during the inspection.

479 Green Lanes provides personal care and support to people living in their own homes or within supported living schemes. There were 207 people using the service at the time of the inspection. The service supports people living with dementia, learning disabilities, mental health conditions and physical disabilities.

There service had 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.

At our last inspection in October 2015, we found that the service did not complete risk assessments where particular personalised risks had been identified. Where people had been noted to have complex needs and health issues, there was no guidance available to staff on how to support people with their care and support needs relating to the identified health condition. This resulted in a breach of Regulation 12 of the Health and Social Care Act 2008.

During this inspection we found that appropriate actions had been taken and improvements had been made. Care plans included appropriate risk assessments personalised to each individual person. In addition to this care plans also contained specific guidance about people's complex needs and health conditions where appropriate.

Care plans that we looked at contained detailed information about the person that required support which included their likes and dislikes and how they wished to be supported. Environmental risk assessments had been completed which highlighted potential risks and how these could be mitigated.

Care plans had been signed either by the person using the service or their relative. People and relatives told us and records confirmed that they were involved in the planning of their care and also confirmed that the service regularly reviewed their care package with them.

The provider had appropriate policies and processes in place in relation to the Mental Capacity Act 2005 (MCA). Records confirmed that staff had received training on the MCA and when we spoke with staff they demonstrated a good awareness and understanding of the principles of the MCA and how these were to be applied when supporting people.

The service had recruitment processes in place which ensured that only suitable staff were employed.

People told us that where staff supported them with their medicines, this was carried out appropriately. We looked at seven Medicine Administration Records (MAR) and found that there were no gaps in recording. MAR charts are the formal record of administration of medicine within the care setting. However, where medicines were administered from a blister pack or dossette box, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. We did note that the service had recorded people's required medicines on the person's care plan but this did not always match the prescribed medicines at the time of our inspection as the medicine information had been obtained during the initial assessment.

Staff told us and we saw evidence that care staff received medicine training on a yearly basis. However, the service did not complete a formal medicines competency assessment to confirm their learning. The administration of medicines was observed during spot checks, where field supervisors carried out observations when care staff were on a care shift. However, the spot checks did not provide any detail about what areas of medicine administration had been observed and checked to confirm competency.

People told us that they felt safe in the presence of the care staff that supported them. Staff demonstrated a good understanding of safeguarding and what this meant in order to ensure people were protected from abuse. Staff knew who to report abuse to which included managers as well as external agencies such as the police, local authority and the Care Quality Commission (CQC).

Overall, people and relatives told us that they were happy with the care that they or their relative received. They received regular and consistent staff who were caring and ensured that their privacy and dignity was maintained at all times. Staff also confirmed that they supported regular people and were allocated to work with people in the same area which was normally local to where they lived.

People and relatives told us that they felt staff were adequately trained and skilled to provide good and effective care. Staff also confirmed that they had received an induction prior to starting work as well as on-going training as part of their personal development. Staff told us and records confirmed that they received regular supervision and had also received an annual appraisal which looked at their overall development and training needs.

People and relatives told us that they knew who to speak with if they had any concerns or issues with the service that they or their relative received. A record was kept by the service of all complaints received. This included details of the complaint and the investigation that had been conducted. Most complaints received had been through the local authority complaints system and therefore the response the service provided with the outcome of their investigation was directly sent to the relevant local authority. The service did not provide any form of response, including an apology where appropriate, directly to the complainant.

A number of quality assurance systems were in place which included staff spot checks, telephone monitoring and annual feedback surveys that people and relatives completed. We saw that the registered manager regularly checked the systems in place for their effectiveness and where actions were noted these were followed up.

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. Staff had received training on how to support people with the administration of medicines. Medicine records confirmed that people received their medicines safely and on time. However, the service did not appropriately complete the Medicine Administration Record (MAR) as per the requirements of the providers medicine policy.

Completed risk assessments assessed people's individualised risks and where a person was noted to have complex needs or significant health conditions, guidance was available to staff so that they were able to support people appropriately and mitigate or reduce any associated risks. However, care plans did not always contain certain details about the care and support a person required. This would be most relevant in an emergency where a new staff member would be required to attend to the call.

There were sufficient staff to ensure that people's needs were met. There was a robust recruitment procedure in place.

Staff were aware of different types of abuse and what steps they would take if they had safeguarding concerns.

Is the service effective?

Good

The service was effective. Staff received regular training in a number of areas and this was refreshed on a regular basis. Staff confirmed that they received regular supervisions and were supported to carry out their role.

Consent was obtained from people or their relatives in accordance with the Mental Capacity Act 2005.

People were supported to maintain their health and access healthcare services where required.

People's care plans detailed where support was required with nutrition and hydration. People and relatives confirmed that staff supported them with their meals and drinks where required and upon request.

Is the service caring?

Good

The service was caring. People and relatives told us that they received a good service from staff who were caring and considerate. People's privacy and dignity was respected.

People and relatives confirmed that they received care and support from regular staff who were knowledgeable about their needs and wishes. Staff also confirmed that they visited regular people and demonstrated a good understanding of people's needs and requirements.

Care plans provided detailed information about the person which included their life history, likes and dislikes and direction on how they would like their care and support to be delivered which promoted independence.

Is the service responsive?

Good

The service was responsive. Each person had a care plan that contained information about them and their assessed need. Care plans were reviewed regularly and involved the person receiving the care and their relative where appropriate.

People and relatives knew how and who to complain to. Where the service had received complaints especially through the local authority there were records confirming the actions taken and the outcome of the complaint. However, the service did not respond directly to the complainant, with an apology where appropriate, confirming the actions taken with the details of the outcome of the complaint.

Is the service well-led?

Good

The service was well-led. People and their relatives knew the person to speak with to discuss their care and support needs. This was not always the registered manager, but was more regularly the care co-ordinators or field supervisors.

The service had systems and processes in place for monitoring the quality of care. Regular staff spot checks and telephone monitoring were carried out to ensure that people received a good service.

Annual quality assurance questionnaires were sent to people and their relatives to complete which were used to monitor the quality of care that people received. The registered manager checked the completed surveys and where issues or concerns were noted the registered manager recorded the actions that

were taken to ensure continuous learning and improvement.

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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.

This inspection took place on 8 and 9 December 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that the registered manager would be available to support us with the inspection process. The inspection visit was carried out by two inspectors on the first day of the inspection and one inspector on the second day of the inspection. In addition, on the first day of the inspection, two experts by experience carried out telephone interviews with people and relatives who used the service. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. We spoke with 11 people using the service and six relatives.

On 9 December 2016, with prior consent, we undertook visits to people's own homes to speak with them about the service that they received. As part of this visit we also looked at records that were held in people's own homes. We visited four people in their own home where we were able to speak with three people and one relative.

Before the inspection we asked the provider to complete a Provider Information Return. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the completed (PIR) and previous inspection reports. We also looked at other information we had about the provider which included notifications of any safeguarding or other incidents affecting the safety and wellbeing of people.

Prior to the inspection we also wrote to a number of professionals which included local authority commissioners for their feedback about the provider.

During the inspection we spoke with the registered manager, one care co-ordinator, two administrators and six care staff members. We also looked at a variety of documents which included 14 people's care plans, risk

assessments, six staff files, meeting minutes, quality audits and surveys and a number of policy documents.

Requires Improvement

Is the service safe?

Our findings

People and relatives told us that they felt safe with the care and support that they received from the service. One person told us, "I feel safe, touch wood." Another person, when asked if they felt safe with the staff that supported them stated, "Yes definitely." A third person said, "Yes definitely because I can trust him in my house." Relative's comments included, "Yes she does. Never been any problems" and "Yes she is alright with them."

At the last inspection on October 2015, we found the provider in breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Although the service carried out environmental and moving and handling risk assessments they did not assess people's individualised risks associated with their care and support needs. In addition, where people were identified to have complex needs and health conditions, there was insufficient guidance available to staff about the identified need or condition to enable staff to appropriately support the person and mitigate or reduce any risks associated with their assessed need.

During this inspection we found that the service had made improvements to their pre-service assessment tool and the home care support plan which was used to provide information and detail to staff about people's assessed care and support needs. In addition to environmental and moving and handling risk assessments, individualised risks such as the risk of developing pressure sores, risk of dehydration and risk of self-neglect had been identified and simple guidance had been provided to staff on how to reduce or mitigate risks whilst supporting people with their needs. One care plan noted, "Change incontinence pad and monitor skin as [name of person] is at risk of developing pressure sores."

Where people had complex needs and health conditions these were assessed and where appropriate specific guidance was provided as part of the care plan. Guidance notes were seen on how to support people with diabetes, dementia care, epilepsy, choking and anaemia. Guidance included information on what the health condition or need was, how to support people with the particular condition, signs and behaviour patterns of concern and the actions to take if there was an emergency.

However, for two care plans we noted that the service had not recorded in the care plan certain details about the care and support a person required. This would be most relevant in an emergency where a new staff member would be required to attend to the call. Staff would not know the details of the care and support required. The care co-ordinator and care administrator that we spoke with were clearly able to explain one person's needs to us which included occasions where the person may not open the door to the staff. It was explained that all staff were aware that they must follow the providers 'no reply' policy but this had not been noted in the care plan. We explained the importance and relevance of this to the registered manager and the management team who agreed that care plans needed to contain this level of detail.

People told us that where staff supported them with their medicines, this was carried out appropriately. One person told us, "Oh yes. They give them to me in the morning and a small amount in the evening. They always give them to me with my meals." Another person stated, "Yes definitely they go and get me a glass of

water." One relative said, "Yes he does. The carer gives him his medication every morning." Another relative commented, "Yes they will only give it to her if it's in a blister pack. She will have it before breakfast."

We looked at seven Medicine Administration Records (MAR) and found that there were no gaps in recording. MAR charts are the formal record of administration of medicine within the care setting. However, where medicines were administered from a blister pack or dossette box, the individual name of the medicine, dose and frequency prescribed was not detailed on the MAR chart. We did note that the service had recorded people's prescribed medicines on their care plan but a copy of this was not always available at the person's home which would ensure that staff had information about the medicines that they were prompting or administering.

One person, whom we visited as part of the inspection, had been prescribed eye drops which required daily administration. The person told us that the district nurses supported them with the eye drops on a daily basis. However, the care staff supporting the person from the agency had recorded in the daily notes that they had, "administered eye drops in both eyes." A MAR chart was not in place recording the administration of the drops. We highlighted this to the care co-ordinator and the management team who were not aware of this but assured us that this would be addressed.

For another person who we visited, we looked at the MAR charts to check whether these were being completed appropriately. Although records were fully complete we noted that where the person had been prescribed tea time and night time medicines, the care staff from the agency who had been allocated a PM call, was attending to the call as early as and between 4:00pm and 6:00pm. We saw that both tea time and night time medicines were administered during that call. This meant that medicines that were due to be given at night were being administered late afternoon or early evening. This was again highlighted to the management team for them to address.

Staff told us and we saw evidence that care staff received medicine training on a yearly basis. However, the service did not complete a formal medicines competency assessment to confirm their learning. The administration of medicines was observed during spot checks, where field supervisors carried out observations when care staff were on a care shift. The spot checks did not provide any detail about what areas of medicine administration had been observed and checked to confirm competency. This meant that the provider could not provide clear assurance and detail that staff were competent in administering medicines.

We recommend that the provider ensures that they are following their own medicines policy and NICE medicine administration guidelines which clearly outlines the requirements placed on domiciliary care agencies to ensure the safe administration of medicines.

Staff told us that they had completed appropriate safeguarding training and certificates confirming this were seen in staff training records. Staff demonstrated a good understanding of the different types of abuse and their responsibilities relating to keeping people safe and reporting any concerns, accidents or incidents. One staff member told us, "I would inform the office straight away." Another staff member said, "I would contact the office and I have to immediately inform the manager." A third staff member when asked about how they would recognise signs of abuse answered, "I would note if there was a change in behaviour."

Staff knew what the term 'Whistle-blowing' meant. Staff identified that they could report abuse concerns outside of the organisation to the local safeguarding authority and the CQC. One staff member told us, "If something is going wrong you inform the authorities such as the CQC, local authority or the police."

People were supported by a team of regular and consistent staff and no concerns were raised about shortages of staff. When we asked people and relatives about whether the staff arrived on time, whether they spent their allocated time and if they were allocated regular care staff we received the following responses. One person told us, "They are on time but I do get a call from the office if they are late and they tell me who is coming." Another person explained, "Yes very good. When they get buses you have to allow for it. When you get used to one you don't like others taking their place." A third person said, "Most of them yes. She [care staff] come in evening and she walks [to my house]. Sometimes half an hour late but she can't help it." Relatives comments included, "Yes they arrive on time. Yes" and "We have regular carers and they are normally on time. They can be late sometimes due to traffic but I have no problem with them."

We looked at six staff records in order to ensure that the service had undertaken safe recruitment checks for each person that it employed. The service obtained two written references and checked various different types of documents to verify a person's identification. Where gaps in employment were identified on the staff members application form, this was discussed as part of the staff member's interview. The service also completed criminal records checks for all staff that they recruited and as good practice re-checked each staff member's criminal record check every three years.

The care co-ordinator showed us the electronic rota and call monitoring system which monitored staff timekeeping and the duration of time spent at each call allocated. Care staff were required to log in and out each time they attended a call using the person's telephone. It was explained that not all people using the service had agreed and given permission for the care staff to use the telephone to log in at the start of the call and log out at the end of the call. When a carer had not logged into the persons home telephone, a text message was sent to a mobile phone which was monitored by management team in the office. The care co-ordinator explained that the system was 90% effective and gave them oversight of staff timekeeping as well as assurance the staff were spending the allocated time at each person's home. Where issues were identified this was addressed with the staff member. Where people had opted out of being part of the call monitoring system, a critical list had been developed so that regular checks were undertaken to ensure people were receiving their care and support in a timely manner. The service confirmed that they had not had any recorded missed visits in the last five months.

In relation to the rota management system, this was not being used to its full potential as the care co-ordinator continued to manually manage and organise rotas. Each staff member was allocated a cluster of people who required support in a particular area so that staff did not have to spend a lot of time travelling to different areas. Rotas were planned on a monthly basis and then re-visited on a twice weekly basis to ensure any changes were reflected on the rota. Staff were then sent text messages and emails with a copy of their rota. Staff that we spoke to confirmed that this was the process and that they were allocated regular people that they supported in one particular area. One staff member told us, "I see the same set of people and I work in a specific area. If I am late I call the person first and then call the office." Another care staff explained, "I am permanent so I have a fixed rota. If there are any changes they [the office] call me or text me. The shifts are local to where I live. I call the clients if I am running late."

An accidents and incident folder was in place with incident forms that would be used to report any accidents or incidents. These forms were also available at the person's home as part of their care folder so that care staff were able to record any witnessed accidents or incidents immediately. There were no recorded accidents or incidents in the last one year.

All care staff had full access to personal protective equipment (PPE). We observed that care staff were able to come to the office and collect the equipment that they required.

Good

Is the service effective?

Our findings

People who used the service and relatives told us that they felt the care staff that supported them were adequately skilled and knowledgeable to provide effective and good care. One person told us, "Yes they know what they're doing. They make notes in their pad of what they have done." Another person stated, "[Name of care staff] is definitely. I ask her to help me get mobile and she is giving me exercises and today I got [walked] to the doorstep." A third person said, "The carer that comes from Monday to Friday could communicate better. She would ask me what I wanted done, do those things and then just walk out." Relatives comments included, "Yes because we have a chat about her memory and things we can do to help" and "Yes they would be."

Prior to commencing employment with the agency, care staff told us and records confirmed, that they had attended an induction programmed which covered training in mandatory topics such as moving and handling, first aid and health and safety. The induction programme was based on the Skills for Care guidelines and the Care Certificate. The Care Certificate is a training course that covers the minimum expected standards that care staff should hold in relation to the delivery of care and support.

We looked at a sample of six staff records. Each staff member had an individual training record on file which stated the training courses undertaken and the dates of completion. Certificates were also available which corresponded with the records. Staff received training in a variety of areas including safeguarding, moving and handling, challenging behaviour, medicines, food hygiene, record keeping and the Mental Capacity Act 2005 (MCA). There was evidence that these were refreshed on a regular basis. The registered manager and management team had developed a training matrix which gave them an overview of each staff member, the training courses that they had completed, the dates these had been completed and when they were next due to receive refresher training.

Care staff were positive about the training that they received from the provider and were confident that if further training needs were identified, that they would be able to approach the registered manager to make a request. One staff member told us, "I get good training opportunities and my training is always up to date." Another staff member stated, "I feel able to make suggestions."

Care staff told us and records confirmed that they received regular supervisions and also received an annual appraisal. Through this process care staff felt supported so that they could effectively deliver care and support to people. One staff member told us, "We have supervisions every three months. They are helpful as we talk about improvements and we can make suggestions which they act on." Another staff member stated, "They ask us if we have any problems but I wouldn't wait until a supervision to tell them." A third staff member said, "Yes, we receive regular supervision with [name of registered manager]. They are helpful as we talk about how the work is going on and if I have any problems and about the clients health."

In addition to supervisions, field supervisors carried out staff spot checks for all staff members. This included observing care staff whilst they were supporting people with their care which included checking areas such as timekeeping, communication, use of appropriate protective clothing, medicines recording and personal

care tasks. Where any concerns or issues were observed these were recorded with details of the actions taken.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack mental capacity to do so for themselves. The Act requires as far as possible people make their own decisions and are helped to do 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 the best interests and legally authorised under the MCA.

We checked whether the service was working within the principles of the MCA. Records showed that all staff had received MCA/DoLS training. The registered manager, members of the management team and all care staff had a good understanding of the MCA and how this impacted on the care and support that people received. One member of staff told us, "If a client is capable of making decisions or not we must tell them what we are doing and ask for their consent." Another staff member explained, "The MCA tells us that we must assume a person has capacity. Where someone lacks capacity, certain decision need to be made involving the family and the office."

People's care files contained a consent form which was signed by the person using the service or where the person was unable to sign the consent form was signed by a relative or next of kin. People told us staff always obtained consent whilst they were being supported. One person told us, "Oh yes, yes. Thank goodness I am fairly well in the head, but it is my legs that are the issues. I dress myself in the mornings but I need sometimes help in the bathroom." Another person said, "Yes they do. They ask before they do anything." A relative told us, "My husband would display by actions what he would want. Also the carer responds by chatting and using actions to implement what my husband wants."

The service provides care to people within their own home. Care staff were not involved in menu planning for people and were not always involved in monitoring people's nutrition and hydration as they would only be present at the person's home at certain times throughout the day for a specific time period. The service did support people with preparing basic meals or heating up ready meals. People and relatives feedback about the support they received with their meals was positive. One person told us, "She'll get me a sandwich and make me soup before she leaves." Another person said, "I ask and they normally just make me a sandwich." One relative told us, "The carer makes a cup of tea for her in the morning. I make the breakfast. If I am not going to be around the carer is very flexible in coming earlier and helping out."

People's nutritional needs were assessed as part of their initial assessment. There was clear information about dietary needs which included likes and dislikes as well as cultural and dietary requirements, for people where support was required. Where people had been assessed with specific and specialist requirements with their nutrition and hydration needs this had been documented and risk assessed. Care plan contained appropriate guidance for staff to follow where people required support with their meal and were at risk of choking.

Most people and relatives we spoke with did not require assistance from the provider to access healthcare services as domiciliary care agencies do not generally support people with healthcare appointments as they provide care such as washing, dressing, medication and food preparation. However, people and relatives were confident that if required care staff would act appropriately and would communicate any concerns or issues. One person told us, "At the moment yes. I have not had any major concerns about my health but I suppose they would [act speedily]." One relative stated, "With the hours that they are given yes. They will let us know quite quickly." Care staff were also able to explain the actions they would take if they felt that a

person was not well and required immediate attention. One staff member stated, "If a person is not well I would call the office, the next of kin and then I would call 999 if it was an emergency."

Good

Is the service caring?

Our findings

People told us care staff were caring, dedicated and some were also willing to do extra jobs where required. Comments from people when asked if staff were caring included, "I should think so. I have had the same carer for four years," "Yes. [Name of staff] wants as much for me to do what I want to do. She has been very good" and "The carers that I have are out of this world. The best carer that I have ever had." Relatives comments included, "Staff are definitely caring," "They do little extra things for us like getting stamps and posting cards" and "Yes this particular one is. That is all I can speak about as that is all we are receiving. There are occasions I come in and she is sitting on the end of the bed talking to her. She genuinely cares about the people."

Care staff spoke passionately about the work that they did and demonstrated a high level of knowledge and understanding about the people they supported. One member of staff told us, "I love working with my clients which is where I get my experience from." Another care staff told us, "I have built a relationship between us [People they support]."

People told us staff respected their privacy and dignity. One person told us, "Yes he respects everything. My husband is satisfied. My husband's dignity is respected by the carer who talks to him softly and caringly and always asks and informs if he needs to do anything differently than he has done before." Another person explained, "Yes. I am a bit proud of myself. I don't like showing my body to people and they respect that." One relative commented, "Yes. This one does. One time the carer said she [my relative] wouldn't let me wash her hair and asked if I could have a word so she didn't try and force her."

Care staff were able to give specific examples of how they made sure people's privacy and dignity was maintained especially whilst they were supported with personal care. One care staff told us, "I would close the blinds or curtains and I would make sure that I did not share the person's information with anyone." Another staff member said, "If the person needed to use the toilet I would support them to the toilet and if safe, I would leave them on their own for a little while until they called me to return."

Care plans included background information, medical history about the person and stated people's preferences around the name they wished to be addressed as, whether they wanted a male or female care worker or where they had a specific communication method which they found easier to understand. A two page summary was available for care staff which gave detail about the person and their specific care needs so that all staff at a glance would be able to support the person with their needs.

People told us they were consulted about their care and involved in planning. One person told us, "Yes. We discussed what I needed and what my requirements were." Another person explained, "Yes I told them what I wanted over the phone." Relatives also confirmed that they were consulted about the care that their relative received. One relative stated, "Yes. Agreeing how many times to have care. The access was arranged when we installed a key safe."

During the inspection we spoke with staff around supporting people with protected characteristics. Some

care staff gave examples of how they supported people with specific cultural and religious needs especially relating to food. One care staff explained how they supported a Turkish person by preparing Turkish meals for the person and communicating with them in Turkish. We asked staff how they would work with lesbian, gay or bisexual people. Staff showed an understanding of this. One staff members told us, "I would treat all people the same." Another care staff said, "It doesn't worry me at all. I am a professional and I am there to support people."

Good

Is the service responsive?

Our findings

People and relatives told us that if they had any concerns or issues they knew who they could contact so that the issues could be addressed. One person said, "Yes they asked right from the beginning if we are happy with the service." Another person confirmed, "Just ring up the office." One relative told us, "I have no complaints. I haven't had to call the office. I have the phone number of the lady who came to assess."

The service had a complaints policy and we saw that complaints were logged and investigated promptly. Records included details of the complaint and the investigation that had been conducted. Most complaints received had been through the local authority complaints system and therefore the response the service provided with the outcome of their investigation was directly sent to the relevant local authority. The service did not provide any form of response, including an apology where appropriate, directly to the complainant. We highlighted this to the registered manager who told us that he would address this immediately.

People confirmed they were offered choice in how they received their care. Staff demonstrated a good understanding of how to promote people's independence by involving them and giving them choice and control over the care that they received. Care staff gave us different examples of how they promoted independence and gave people choice. One staff member told us, "Everything is centred on the client. You consult him and involve him." Another staff member stated, "You treat every client as an individual. Each person has their own beliefs. You would consider their care plan."

People and relatives told us they received personalised care which was responsive to their needs. Care plans were person centred and detailed all tasks that needed to be completed and prompts for staff to complete all records, report any falls, where the use of a hoist was required that this was to always be completed with two staff members present and maintain dignity and respect at all times. A pre-service assessment was completed which noted people's needs, requirements and preferences. A health and safety checklist was also completed as part of the pre-service assessment. Care plans seen at the main office were also available at the homes of the people we visited. This meant that care staff had access to the most up to date care plan.

Care plans were reviewed on an annual basis or sooner if required and these were completed together with the person and where required their relative. Where issues and concerns were expressed these were recorded as part of the review. However, for one care review we noted that the relative had expressed the need for additional support. The service had not recorded what action had been taken as a result of this request. The registered manager explained that a request would have been submitted to the commissioning authority but there was no record available of this. The registered manager had a system in place whereby, when a request for additional care was made a referral form was available to be completed and sent to the commissioning authority but that this form had not been completed in this instance.

Daily contacts sheets were used to record the date of the call, the time the care staff arrived and left, details of the care and support that was delivered and any other essential information relating to the persons care, support and health needs. The records that we checked when visiting people at their own home were

complete and contained details of the care and support that had been provided.

Good

Is the service well-led?

Our findings

Most people and relatives we spoke with did not know who the registered manager was. However, most had spoken to and knew of the care co-ordinator and some field supervisors. People were able to name those members of staff and also confirmed that they had contact details for them and were confident in contacting them if they had any issues or concerns. One person told us, "No I have not met or spoken to them." Another person told us, "I've spoken to [Name of co-ordinator]." A third person did confirm they knew the registered manager and said, "Yes, it's [Name of registered manager]." Relatives comments included, "We have a support co-ordinator, [Name of co-ordinator]. We are always in contact with him" and "[Name of co-ordinator] - I have spoken to him quick a few times. He is okay. Only a couple of issues but they were dealt with. I have a number for him too."

The provider had a number of quality assurance systems in place to check and monitor the provision and delivery of personal care and support. One process included regular staff spot checks. Staff spot checks were observation based and were completed by the field supervisor and included observing performance of staff in areas such as medicines recording, infection control, timekeeping and communication. However, the spot checks did not provide any specific detail about what was observed. The form completed was a tick box exercise and we could not confirm what process of care and support had been observed and assessed. For example, where people were observed supporting people with medicines, there was no detail available on the form as to what process was observed and checked to confirm competency. This meant that the provider could not provide clear assurance and detail that staff were competent in administering medicines. This was highlighted to the registered manager who assured us that he would address this to ensure competencies were assessed in more detail.

The registered manager told us that as part of the spot check and review process, the field supervisors would also quality check the care plan of the person whose care and support needs were being reviewed or where a spot check was being undertaken.

In addition to the spot checks the service also carried out annual quality assurance surveys as well as monthly telephone monitoring checks. Questionnaires asked people and relatives to give feedback about whether the care staff were respectful, if they completed the tasks identified in the care plan and their overall opinion of the service that they received. When we asked people and relatives if they had completed any questionnaire one person told us, "Yes they call from time to time. It gives you confidence that they take the trouble to phone." One relative said, "If there is a problem they always call me. He has in the past called me to check on the service they provide to mum." However, the registered manager may want to note that there were some people and relatives who told us that they had not received a phone call or a survey to complete. One person said, "I don't think they have called me to find out how things are, probably too busy." One relative who had only recently begun using the service told us, "I've not had a phone call to ask how things are going."

Completed questionnaires and telephone monitoring checks recorded any issues or concerns that the person or relative raised with details of the actions that had been taken as a result of the feedback. The

registered manager also checked and signed each completed questionnaire as part of his management oversight.

Staff told us that they felt supported by the registered manager and the management team overall. One member of staff told us, "He [registered manager] listens. I have not worries about raising concerns." Another staff member said, "The registered manager is friendly and approachable. He always asks if you have any problems." A third staff member stated, "[Name of registered manager] is so approachable. Anything you don't feel comfortable with you can come to him."

The office ran an open door policy and care staff were observed to visit the office as and when they required. Reasons for visits included collecting personal protective equipment, collecting rotas and payslips. We observed care staff have friendly conversations with the registered manager and other office based staff. The service had a clear management structure in place with designated office staff to support people and care staff. During the first day of the inspection, hoist training had been scheduled and was delivered in the training room within the office. Appropriate facilities and tools were available to staff to support learning and development.

Care staff told us and records confirmed that the office regularly communicated with them by telephone, text messaging and monthly memos. Every month a memo was produced and attached to staff members payslips outlining key issues that needed to be communicated to care staff. Issues highlighted included timekeeping, no reply and what to do and informing the office if running late.

Staff meetings took place on a regular basis. Care staff told us and records confirmed that meetings took place every three to four months. The last meeting took place in June 2016. Topics discussed included the importance of record keeping and making sure reports were sufficiently detailed and accurate, time keeping and following the medicine policy. One staff member told us, "Staff meetings are every four months. If I am unable to attend [Name of administrator] will give me a rundown of what was discussed and if there is anything to read will sit me down to read."

Staff were asked to complete annual staff satisfaction surveys. The survey asked staff questions around training, whether they feel supported and if they had any suggestions for improvement. Feedback given was generally positive. The registered manager reviewed all completed surveys and where suggestions had been made this had been recorded so that learning could take place and improvements where possible could be implemented.

One area of improvement that the provider was considering was paying care staff for their travel time. Care staff told us and records confirmed that care staff were mostly allocated to work in the locality that they lived in, therefore minimising the need for excessive travel. However, there were some care staff that travelled excessively around a number of local areas, and for staff this applied to, the plan was to introduce an additional payment which would cover their travel costs.