

First Call Community Systems Limited

SureCare (Bolton)

Inspection report

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Ratings

Overall rating for this service

Good 

Is the service safe?

Good 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Good 

Is the service well-led?

Good 

Overall summary

The announced inspection took place on 04, 05 and 06 November 2015. At our last inspection on 24 June 2013 the service was found to be meeting all regulatory requirements.

The provider was given 48 hours' notice of the inspection to ensure management were available at their office to facilitate our inspection. At the previous inspection on 24 June 2013 the service was found to be meeting all regulatory requirements.

Surecare (Bolton) is a domiciliary agency which provides personal care for adults in their own homes. Clients can self-refer or care is commissioned by the local authority. The office is based on one of the main roads in Farnworth, Bolton. At the time of the inspection, 64 people were using the service.

At the time of the inspection there was no registered manager in post but a member of staff was going through the process of registering with the Care Quality Commission. A registered manager is a person who has

Summary of findings

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.'

People we spoke with told us they felt safe using the service. During the inspection we checked to see how the service protected vulnerable people against abuse. There was an up to date safeguarding vulnerable adults policy in place. We found that the staff we spoke with had a good knowledge of the principles of safeguarding.

The provider had a whistleblowing policy in place and this included contact details for the Care Quality Commission but details for the local safeguarding authority were missing.

Each care file contained a variety of risk assessments. There was a 'generic risk assessment', an 'individual risk management' document a 'manual handling' risk assessment. There were risk assessments for falls, bathing, showering and medication. We found these risk assessments were reviewed as required in response to changing needs of the person who used the service.

We looked at how the service managed people's medicines and found that suitable arrangements were in place to ensure that people who used the service were safe. All staff administering medication had received training, which we verified by looking at training records. An up to date 'medication management policy' was available for staff and a 'policy for medication to be taken as required' was also in place which instructed staff how to accurately administer and record these medicines.

We found people were receiving care from care staff who were deployed consistently in a way that met people's needs. Some people who used the service lived alone and staff required the use of a key to access their house. We saw the keys were appropriately stored in a 'key safe' outside each house we visited.

We found there were suitable recruitment procedures in place and required checks were undertaken before staff began to work for the service. Each staff file contained a contract and job description which had been signed and dated.

We saw evidence of a comprehensive induction pack, with appropriate training provided for roles and responsibilities, along with competency testing. Staff also signed to confirm they had read policies and procedures and that they were aware of the provider's requirements in respect of data protection and confidentiality.

There was an appropriate up to date accident/incident policy and procedure in place. Records of accidents and incidents were recorded appropriately within people's care files.

There was an up to date 'business continuity plan' in place which covered areas such as loss of utility supplies, loss of staff, office damage, loss of IT systems and adverse weather.

People who used the service told us they felt that staff had the right skills and training to do their job.

At the time of the inspection the service was in the process of introducing 'StaffPlan' which is a computer software programme specifically produced for the care and support sector to assist them in organising the deployment of staff.

We found there was a staff induction programme in place, which staff were expected to complete when they first began working for the service. Staff told us they felt they had received sufficient training to undertake their role competently. We reviewed the service's training matrix, and staff training certificates, which showed staff had completed training in a range of areas, including training in dementia, moving and handling, behaviours that challenge services, safeguarding, first aid, medicines, infection control and health and safety.

All care staff were given a staff handbook that included policies and procedures, which was discussed with the staff member as part of the induction process.

Staff received supervision and appraisal from their manager. These processes gave staff an opportunity to discuss their performance and identify any further training they required.

Before any care and support was provided, the service obtained consent from the person who used the service or their representative. We were able to verify this by speaking with people who used the service, checking people's files and speaking to staff.

Summary of findings

Care files contained a 'data protection service user consent' form, a 'medication administration authorisation' form, a 'consent to care and treatment' form and details of whether the person could sign documentation themselves or if a family member was required.

We found from looking at people's care records that the service liaised with health and social care professionals involved in people's care if their health or support needs changed and the service worked alongside other professionals and agencies in order to meet people's care requirements where required.

We saw that people's nutrition and hydration status was recorded in a 'full care needs assessment' document which identified if the person required assistance with eating, drinking and shopping.

We spoke with staff to ascertain their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Two staff told us they had previously completed training in MCA and DoLS. We checked staff training records to see which staff had completed MCA and DoLS training and saw that 75% of staff had completed this training.

People who used the service and their relatives told us that staff were kind and treated them with dignity and respect and that they and their relatives were involved in developing their care and support plan where they wished. Whilst visiting people in their own homes we observed warm interactions between people and staff.

The service had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose, which is a document that includes a standard required set of information about a service. There was also a 'SureCare Guide to your Support Service' document which included a 'customer charter', 'principles of care', 'independence', 'choice', 'emotional needs and fulfilment'. These documents included details of how to make a complaint and referenced the local authority, the Care Quality Commission and the Local Government Ombudsman.

We saw there was a 'customer care' policy, which was up to date and recently reviewed. Other supporting policies included 'confidentiality', 'nutrition and diet', 'bathing and showering', 'bed bathing', 'handling service user's money', 'no response', 'dealing with emergencies', 'key holding',

'use of personal protective equipment' and 'challenging behaviour' policies. There was also a resident's 'charter of rights' and a policy on 'autonomy and choice', which helped staff to understand how to respond to people's different needs. Staff were aware of these policies and how to follow them.

We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s). We verified this by looking at care records.

People told us that should there be a need to complain they felt confident in talking to the manager directly and had regular discussions with management. The service had a complaints policy and procedure and we saw that they followed this consistently. Complaints and concerns investigations had been carried out following issues raised regarding quality of service provision and missed visits and the service had taken remedial action to reduce the potential for a reoccurrence.

The service sought the views of people using the service and their relatives. We saw that a quality assurance survey/service user's views questionnaire had been undertaken and completed in January 2015. Another survey was due to be undertaken in November 2015 after the date of the inspection. We saw that remedial action had been taken to resolve the issues identified in the survey.

People who used the service had a care plan that was personal to them with copies held at both the person's own home and in the office. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care. Regular reviews of care needs were undertaken by the service. The manager told us that all care files had recently been reviewed and that a rolling programme of reviews was followed every three months. We looked at records and saw that there was an up to date log of care file reviews for 2014 and 2015.

People told us that they were listened to by the service.

The manager told us that if the service received a new referral it would not be accepted until it was certain that there were enough staff available to meet the person's care needs. This may have included whether there was a need to recruit additional staff.

Summary of findings

There were systems in place to record what care had been provided during each call or visit. Care plans contained a document, which was completed by staff at each visit.

There was no registered manager at the service. At the time of the inspection one member of staff was in the process of registering with the Care Quality Commission to become the registered manager.

Staff told us they felt they were able to put their views across to the management, and felt they were listened to. The staff we spoke with told us they enjoyed working at the service and said they felt valued.

The service undertook audits to monitor the quality of service delivery. We saw a number of audits in place such as care file and medication audits, and spot checks on care staff to verify their competence in providing safe and good quality care.

We found the service had up to date policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control.

Audits of medication administration had been completed which the service shared with the local authority contracts monitoring team as requested. Staff we spoke with confirmed they had been subject to audits of their practice through direct observation and questioning.

The service had a business continuity plan in place which covered areas such as loss of access to the office, loss of staff, loss of utilities and the action to be taken in each event. The plan also included the prioritising of people who used the service with regards to their individual needs.

The service had recently produced five 'service development' files that were being used to help identify if the service was meeting all the regulatory requirements. To support these files, an action plan had been developed in 2015 and was due for review in January 2016.

The service had recently set up a new 'on-call' rota for out of office hours telephone contacts, which was supported by an on-call file that recorded all calls received.

The manager said they endeavoured to explain any instructions or changes in practice to the staff group so that they understood why the request or instruction was being made.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

The service was safe.

People we spoke with told us they felt safe using the service.

All care staff had undertaken safeguarding training. There was an up to date safeguarding vulnerable adult's policy in place.

Each person's care file contained a variety of risk assessments.

Suitable arrangements were in place to ensure the safe management of medicines.

There were suitable recruitment procedures in place and required checks were undertaken before staff began to work for the service.

Good



Is the service effective?

The service was effective.

People were not consistently informed if there was a change to their scheduled care and support arrangements.

There was a staff induction programme in place, which staff were expected to complete when they first began working for the service and staff told us they felt they had received sufficient training to undertake their role competently.

Training was mostly provided via e-learning through 'Social Care TV' and all refresher training was linked to the Care Certificate.

Staff received supervision and appraisal from their manager.

In one care plan that we looked at the 'consent to care and treatment' form had not been signed and dated.

Not all staff had completed training in MCA/DoLS.

Good



Is the service caring?

The service was caring.

People who used the service and their relatives told us they felt the service was caring.

People who used the service and their relatives told us they were involved in developing their care and support plan.

Staff adequately described how they aimed to treat people with dignity and respect when providing care and how they encouraged people's independence.

The service had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose.

Prior to any new admission a pre-assessment was carried out with the person and their relative(s).

Good



Summary of findings

There was a 'dignity champions' notice board in the office staff room which included a 'dignity champion's action pack' and details of safeguarding processes.

Is the service responsive?

The service was responsive.

People told us that should there be a need to complain they felt confident in talking to the manager directly and that they were listened to by the service.

The service had a complaints policy and procedure and followed this consistently.

The service sought the views of people using the service and their relatives.

People who used the service had a care plan that was personal to them.

Regular reviews of care needs were undertaken by the service.

There were systems in place to record what care had been provided during each call or visit.

Good



Is the service well-led?

The service was well-led.

There was no registered manager in post. One person was in the process of registering with the Care Quality Commission to become the registered manager.

The staff we spoke with told us they enjoyed working at the service and felt valued, were able to put their views across to the management, and felt they were listened to.

The service undertook audits and had policies and procedures in place to monitor the quality of service delivery.

The service used an electronic call monitoring system (ECM) as required by the local authority but there had previously been a high number of manual overrides.

We saw audits of medication administration had been completed.

There was an up to date 'business continuity plan' in place.

Good



SureCare (Bolton)

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 04, 05 and 06 November 2015 and was announced. The provider was given 48 hours' notice of the inspection to ensure management were available at their office to facilitate our inspection. The inspection team consisted of one adult social care inspector from the Care Quality Commission.

Before the inspection visit we reviewed the information we held about the service, including the Provider Information Return (PIR), which the provider completed before the inspection. The PIR 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 information we had received since the last inspection including notifications of incidents that the provider had sent us. We also liaised with external agencies including the contract monitoring team from the local authority.

During our inspection we went to the provider's head office and spoke with the operations director, the business development manager, the care manager, the administrator, four care staff members and the care coordinator.

At the time of our inspection there were 64 people who were using the service, which employed 31 members of care staff. At the time of the inspection two new staff members were being recruited but had not yet started employment.

We reviewed the care records of six people that used the service and records relating to the management of the service. We looked at documentation such as care plans, staff personnel files, policies and procedures and quality assurance systems. We visited four people who used the service in their own home and we spoke with two other people who used the service and to the relatives of two people who used the service over the telephone as part of the inspection. This was in order to seek feedback about the quality of service being provided.

Is the service safe?

Our findings

People we spoke with told us they felt safe using the service. One person who used the service told us; “I have always felt safe and have the details at home if I need to make a complaint to the office or social services.” Another person said: “They (the staff) take their shoes off at my request, then wash and dry their hands and put gloves on to prevent infections. Most staff do this but on occasion they don’t so I remind them.”

All care staff had undertaken safeguarding training. There was an up to date safeguarding vulnerable adults policy in place which referenced Bolton Council's multi-agency Safeguarding Adults Partnership. We asked one member of staff what they would do if they suspected a family member of abusing people who used the service and they stated that they would contact the office and speak to their manager. Another member of staff said: “If I had any concerns about the manager I would speak to a higher manager and I have the contact details for the local authority if necessary.”

We found that the staff we spoke with had a good knowledge of the principles of safeguarding and were able to explain exactly what it meant and what action was required if they suspected any abuse.

There was a ‘safeguarding incidents’ book in use in which staff recorded the safeguarding reference number and raised date, the corresponding Care Quality Commission’s statutory notification, an account of the incident, a record of the outcome and date resolved, details of other professionals involved such as the Local Authority, family members or the Community Mental Health Team.

The provider had a whistleblowing policy in place. We looked at the whistleblowing policy and this told staff what action to take if they had any concerns or if they had concerns about the manager and this included contact details for the Care Quality Commission but details for the local safeguarding authority were missing. Staff told us they were aware of this policy and understood how to use it.

Each care file contained a variety of risk assessments. There was a ‘generic risk assessment’ which included the physical environment in the person’s own home that helped to identify any hazards to the person themselves and the staff member providing support. Care files also contained an ‘individual risk management’ document which identified

various risks and the action required to minimise the risk. This was supported by a ‘manual handling’ risk assessment, which covered bed manoeuvres, transferring, standing and using the toilet. There were risk assessments for falls, bathing, showering, nutrition and medication. We found these risk assessments were reviewed as required in response to changing needs of the person who used the service.

We looked at how the service managed people’s medicines and found that suitable arrangements were in place to ensure that people who used the service were safe. We looked at a sample of two medication administration record (MAR) sheets. We found these had been correctly completed with no omissions or signature gaps. We looked at records and saw that the service undertook competency checks of staff who administered medication. All staff administering medication had received training, which we verified by looking at training records.

An up to date ‘medication management policy’ was available for staff and a ‘policy for medication to be taken as required’ was also in place which instructed staff how to accurately administer and record these medicines. Medication administration training was undertaken at induction, with refresher training subsequently organised when it was due. A ‘medication administration record’ audit had been completed by Bolton NHS Foundation Trust shortly before the date of the inspection in October 2015 and the service had achieved an acceptable result of 76% compliance against the required standards as outlined in the Adult Social Care Services PPD Medicines Policy version 7, June 2014.

We spoke with people who used the service and were told by one person that they self-medicate but: “Staff always ask if I have taken my medicines when they come.” Staff described their responsibilities in respect of medication administration and had undergone medication administration training.

We looked at how the service ensured there were sufficient numbers of staff to meet people’s needs and keep them safe in their own home. We found people were receiving care from care staff who were deployed consistently in a way that met people’s needs. One person who used the service told us; “I think (my relative) is safe and I have no

Is the service safe?

concerns at all with staff.” The manager told us that in the event of an unexpected shortage of staff they could call on another local branch for staffing support in order to avoid the need for agency staff.

Some people who used the service lived alone and staff required the use of a key to access their house. We saw the keys were appropriately stored in a ‘key safe’ outside each house we visited. This required staff to enter a pin code before gaining access to the key so they could go in and deliver care safely.

We found there were suitable recruitment procedures in place and required checks were undertaken before staff began to work for the service. Personal details had been verified and at least two references had been obtained from previous employers. Criminal Records Bureau (CRB) checks or Disclosure and Barring (DBS) applications had been obtained. A DBS check helps a service to ensure the applicant’s suitability to work with vulnerable people. There was also evidence of identity and address checks. This showed us that staff had been recruited safely.

During the inspection we looked at five staff personnel files. We saw evidence in these files of appropriate disciplinary action being taken where relevant and there was an up to date ‘disciplinary and dismissal procedure’ in place.

Each staff file contained a contract and job description which had been signed and dated.

We looked at how the service managed accidents and incidents. There was an appropriate up to date accident/incident policy and procedure in place. Records of accidents and incidents were recorded appropriately within people’s care files.

There was an up to date ‘business continuity plan’ in place which covered areas such as loss of utility supplies, loss of staff, office damage, loss of IT systems and adverse weather. The plan also identified ‘priority levels’ for people using the service which referenced different levels of vulnerability and how people would be supported in the event of a business continuity issue.

Is the service effective?

Our findings

People who used the service told us they felt that staff had the right skills and training to do their job. A relative of a person using the service told us they were always informed if care staff had any concerns about (their relative). One family member said: "I'm involved in care planning and I'm always kept informed of any changes. The staff on the ground are very good." A person who used the service told us: "Lack of communication is an issue these past few weeks. Sometimes the office doesn't always let me know if the staff are going to be late. They (the staff) have the same duties each day usually and they explain first. They ask what I need and what they need to do for me. I tell them what I want such as food etc."

Another person said: "Generally staff aren't rushed and stay for the length of time given and day-to-day care is brilliant." The relative of another person said: "I think staff have the skills and competencies in assisting with medicines and the medication administration records (MAR) are always completed properly."

At the time of the inspection the service was using an electronic staff scheduling and planning tool and were in the process of replacing this system with a new computer software programme specifically produced for the care and support sector to assist them in organising the deployment of staff. This would assist in reducing the potential for missed or late visits.

We found there was a staff induction programme in place, which staff were expected to complete when they first began working for the service. The induction covered areas such as health and safety, infection control, safeguarding, moving and handling, protection of vulnerable adults, food hygiene, confidentiality and medication.

We spoke with two care staff who confirmed the recruitment process they had undertaken.

Comments included: "The induction process helped me to feel confident", and: "I had an induction period when I doubled-up with other staff for a week or so until I felt confident." We saw from looking at personnel files that staff completed a probationary period, with documented reviews.

Staff told us they felt they had received sufficient training to undertake their role competently. We reviewed the service's

training matrix, and staff training certificates, which showed staff had completed training in a range of areas, including training in dementia, behaviours that challenge services, safeguarding, first aid, medicines, infection control and health and safety.

During the inspection we checked to see how the service protected vulnerable people against abuse. We looked at staff training records and found that 100% of care staff had undertaken safeguarding training. The manager told us that as part of the staff induction training there is discussion about the company's policies around safeguarding, the routes for reporting abuse including individual responsibilities from alerting and investigating cases of abuse, and the whistle blowing policies. Additionally 75% of staff had completed training in the Mental Capacity Act and the Deprivation of Liberty Safeguards (MCA/DoLS).

We saw evidence of a comprehensive induction pack, with appropriate training provided for roles and responsibilities, along with competency testing.

All care staff were given a staff handbook that included policies and procedures, which was discussed with the staff member as part of the induction process. New staff members were required to work alongside more experienced care staff during the induction period. We found training was mostly provided via e-learning through 'Social Care TV' and all refresher training was linked to the Care Certificate.

The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life. Individual staff progress against the care certificate requirements was checked weekly and discussed in supervision meetings with the individual and their manager. Drop-in sessions at the office were arranged two days each week for staff who did not have access to the internet at home, and printed workbooks were provided to these staff members for each standard. Staff were also supported to do this training through practical observations, and mentoring from other staff members.

Staff received supervision and appraisal from their manager. These processes gave staff an opportunity to discuss their performance and identify any further training they required. Staff told us they received supervisions every two to three months and an annual appraisal. We checked records to verify this. One staff member said: "I had

Is the service effective?

supervision last week and said I wanted first aid training so this was arranged and recorded on the meeting notes. I think we (the staff) get enough training but I suppose there's always something new to do."

We looked at the way the service managed consent for any care and support provided. Before any care and support was provided, the service obtained consent from the person who used the service or their representative. We were able to verify this by speaking to people who used the service, checking people's files and speaking to staff. We asked a member of staff how they would ensure a person had provided consent to care and they said: "There's a form at the front of people's care files that they sign at the beginning." Another staff member said: "Different people have different needs so it's important to ask the person before doing anything and keep talking to them whilst doing it."

Care files contained a 'data protection service user consent' form, a 'medication administration authorisation' form, a 'consent to care and treatment' form and details of whether the person could sign documentation themselves or if a family member was required. In one care plan that we looked at the 'consent to care and treatment' form had not been signed and dated which meant that the person may not have agreed with the type of support being provided..

The service had a 'Healthcare Providers Handbook on Muslim patients' which had been obtained following concerns raised informally by a family member about culturally sensitive personal care which had been discussed at recent meetings. We found that as a result of this meeting the care plan for the person using the service had been updated to include details of how the person wished to be supported by staff.

We found from looking at people's care records that the service liaised with health and social care professionals involved in people's care if their health or support needs changed and the service worked alongside other professionals and agencies in order to meet people's care requirements where required. Involvement with these services was recorded in care plans and included opticians, chiropodists and doctors. We saw that people's nutrition and hydration status was recorded in a 'full care needs assessment' document which identified if the person required assistance with eating, drinking and shopping. These were supported by fluid intake/output records and a weekly food diary which were in people's care files.

We spoke with staff to ascertain their understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). 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. At the time of the inspection no-one was being deprived of their liberty.

We saw that any equipment used in individual's homes was documented and staff had signed to confirm they were competent in the use of that equipment.

Is the service caring?

Our findings

People who used the service and their relatives told us that staff were kind and treated them with dignity and respect. One person told us: "All the staff are okay, I talk to the staff who visit me and tell them if I am not happy and I feel they respect my privacy." Another person said: "I'm happy with SureCare and I get on well with the staff. New staff are consistent and they let me know if they are going to be late." The relative of another person who used the service said: "I can't fault the staff, and I know the manager who rang me yesterday. I feel that staff respect (my relative's) privacy and dignity."

There were a large number of 'thank you' cards that had been received from people using the service and their families. One card read: 'Thank you to all who looked after (my relative). We could not have kept (my relative) at home without your help and support. Your dedication and caring was appreciated so much by (my relative) and the family.' Another card read: 'Just a few lines to thank you for your support over the past two years. You have all helped towards allowing (my relative) to live independently in their home. We could not have done it without you.'

People who used the service and their relatives told us they were involved in developing their care and support plan. They were able to identify what support they required from the service and how this was to be carried out. One person told us; "Day to day care is brilliant and I'm involved in care planning."

We asked staff how they aimed to treat people with dignity and respect when providing care and how they encouraged people's independence. One member of staff said: "Every person is individual so I would look at people's care plans to understand the support needed and then talk to the person whilst I'm supporting them." Another staff member told us: "If I was dressing someone I would close the curtains and shut any doors especially if there was anyone else in the house. If I was helping someone to get washed I would cover up the parts of their body not being washed so as to ensure privacy and dignity." Another staff member described how they assisted with a person living with dementia and how it was important to the person to

keep the same staff member for reasons of familiarity and continuity. They said: "It's about treating people in the way I would expect to be treated so that people know they can trust me."

Staff also signed to confirm they had read policies and procedures and that they were aware of the provider's requirements in respect of data protection and confidentiality.

Whilst visiting people in their own homes we observed warm interactions between people and staff. It was clear that staff knew people very well and had developed a positive relationship with them.

The service had a Service User Guide and this was given to each person who used the service in addition to the Statement of Purpose, which is a document that includes a standard required set of information about a service. There was also a 'SureCare Guide to your Support Service' document which included a 'customer charter', 'principles of care', 'independence', 'choice', 'emotional needs and fulfilment'.

We saw there was a 'customer care' policy, which was up to date and recently reviewed. Other supporting policies included 'confidentiality', 'nutrition and diet', 'bathing and showering', 'bed bathing', 'handling service user's money', 'no response', 'dealing with emergencies', 'key holding', 'use of personal protective equipment' and 'challenging behaviour' policies. There was also a residents 'charter of rights' and a policy on 'autonomy and choice', which helped staff to understand how to respond to people's different needs. Staff were aware of these policies and how to follow them.

At the time of the inspection the service was not supporting anyone who was in receipt of end of life care but the service had an 'end of life care' policy that was up to date. Care files included an 'end of life care plan' which was used in conjunction with the 'care and support plan'.

There was a 'dignity champions' notice board in the office staff room which included a 'dignity champion's action pack' and details of safeguarding processes. Dignity was promoted within the service by the development manager and two identified members of staff who were dignity champions.

Is the service responsive?

Our findings

A person who used the service told us: “When I came out of hospital I had a pressure sore but SureCare have been managing this and it’s nearly gone now.” Another person said: “There are some good staff in Westhoughton and they always make sure you have everything you need before they go.” A ‘thank you card’ received by the service read: ‘I would like to say a big thank you for the care given to (my relative) when her electric went off. (The staff) stayed with us until the power went back on which was after midnight, we could not have got through without them, they were angels.’

People told us that should there be a need to complain they felt confident in talking to the manager directly and had regular discussions with management. One person told us: “I have details of how to complain at home and I would go to the office first and then to social services if I needed to.”

The service had a complaints policy and procedure and we saw that they followed this consistently. We saw evidence where complaints had been recorded and complaints and concerns investigations had been carried out following issues raised. Recent issues included quality of service provision and missed visits and the service had taken remedial action to reduce the potential for a reoccurrence. Most people told us they had never had to complain and that if there were any issues they could be resolved by talking to the staff or manager. One person told us they had recently made a complaint about a missed visit and were waiting for a response from the service within the timescale identified in the complaints policy.

The service sought the views of people using the service and their relatives. We saw that a quality assurance survey/ service user’s views questionnaire had been undertaken and completed in January 2015. Another survey was due to be undertaken in November 2015 after the date of the inspection. Feedback from the survey in January identified 50% of people rated the service as excellent, 40% rated the service as very good and 10 % rated the service as good. 92% of people said they would recommend SureCare to a friend or neighbour. Every person using the service had received an initial telephone review in October 2015.

From this information the service had produced a quality assurance summary that was distributed to all staff. We saw

that remedial action had been taken to resolve some of the issues identified in the survey. For example, office procedures had been changed to ensure an efficient response to calls from people using the service and a new electronic call monitoring system was being introduced to ensure consistency of support.

The Surecare ‘Guide to your service’ document included details of how to make a complaint and referenced the local authority, the Care Quality Commission and the Local Government Ombudsman. We saw that prior to any new admission a pre-assessment was carried out with the person and their relative(s) which we verified by looking at care records

People who used the service had a care plan that was personal to them with copies held at both the person’s own home and in the office. This provided staff with guidance around how to meet their needs, and what kinds of tasks they needed to perform when providing care.

The structure of the care plan was clear and easy to access information. The care plans were person centred and contained details regarding the person’s background and life history, interests and social life, any existing support network, spiritual needs and recorded details of people who were involved in care planning such as family members and other relevant professionals.

Regular reviews of care needs were undertaken by the service. The manager told us that all care files had recently been reviewed and that a rolling programme of reviews was followed every three months. We looked at records and saw that there was an up to date log of care file reviews for 2014 and 2015. The manager also told us that they visited people in their own homes to identify their views and experiences which was confirmed by the people we spoke with. An annual survey was also carried out by ‘head office’ and a copy of the report was sent to the service manager.

People told us that they were listened to by the service. For example a person who used the service told us: “When my care plan was reviewed they (the staff) discussed it with me, recorded the changes and brought the new paperwork back and put it in my file at home.” The relative of one person told us how the service worked flexibly to allow the relative a period of respite. They said that the service always tried to ensure the same member of care staff to ensure familiarity and continuity of care provision.

Is the service responsive?

The manager told us that if the service received a new referral it would not be accepted until it was certain that there were enough staff available to meet the person's care needs. This may have included whether there was a need to recruit additional staff. The type and amount of care people received, was determined by the local authority commissioning team and this information was provide to the service who fed the details into the electronic staff scheduling system to ensure staff were deployed at the requested times.

Staff, on occasions, undertook shopping for people who used the service. Records were made of all financial

transactions, which were signed by the person who used the service and the staff member. This was supported by a 'gifts and bequests' and 'handling service users money' policy and a 'financial transaction record' form.

There were systems in place to record what care had been provided during each call or visit. Care plans contained a document, which was completed by staff at each visit. This included when personal care had been provided, any food preparation, medication given or any creams applied. We checked these documents and found they were being filled in correctly by staff.

Is the service well-led?

Our findings

There was no registered manager at the service. 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 previous registered manager left the service approximately four months prior to the date of the inspection and in the interim period the service had taken all reasonable steps to recruit a new person. At the time of the inspection one member of staff was in the process of registering with the Care Quality Commission to become the registered manager.

A staff member told us: "The management have got better over the last two years. I've had recent audits of my medicines administration and the manager has asked for my views on training that I have done. I feel free to give any feedback about the service. Another staff member said: "I feel 100% certain that I can approach managers, they are brilliant." The relative of one person said: "The management has improved recently and communication is much better." A person who used the service told us: I know who the manager is and they have visited me at home recently."

Staff told us they felt they were able to put their views across to the management, and felt they were listened to. The staff we spoke with told us they enjoyed working at the service and said they felt valued. They said they thought the management were fair and approachable, and also told us the staff team worked well together. It was clear from our observations that the management team worked well together in a mutually supportive way. The service also worked in partnership with the local authority contracts monitoring team.

The service undertook audits to monitor the quality of service delivery. We saw a number of audits in place such as care worker file and medication audits, and spot checks on care staff to verify their competence in providing safe and good quality care.

We found the service had policies and procedures in place, which covered all aspects of service delivery including safeguarding, medication, whistleblowing, recruitment, complaints, equality and diversity, moving and handling and infection control. These policies were all up to date.

The service used an electronic call monitoring system (ECM) as required by the local authority which identified the dates and times of scheduled visits to people and the actual time spent with the person. The manager said there were sometimes discrepancies with this system which had led in the past to missed visits. The replacement system was due to become 'live' shortly after the date of the inspection.

We saw that the service had previously identified a high level of 'manual overrides' on the electronic system which were above the 15% limit acceptable to the local authority. This had been identified by the service within an 'improvement action plan'. Where visits were not at the time scheduled, the service had provided an explanation to the local authority contracts team and an apology to the person using the service. The service had investigated the number of missed visits in partnership with the local authority and some of the visits were cancelled by people using the service, some visits were out of the scheduled time-banding but some visits were missed. This was partly due to alerts on the on-call phone not being acted on.

We saw that the service had identified a number of actions required to resolve this issue, including additional staff training to all office staff on how to produce ECM reports, the identification of a dedicated staff member within the office and the implementation of a new electronic call monitoring system.

We spoke with the local authority contracts monitoring team to ascertain the number of missed visits for the three months prior to the date of the inspection, August 2015 to October 2015 and found that there were six missed visits and one visit outside of the scheduled allocated time banding. The majority of missed visits had occurred in September 2015. This meant that people were potentially placed at risk by not receiving their scheduled care in accordance with their agreed support plan.

Is the service well-led?

We saw audits of medication administration had been completed which the service shared with the local authority contracts monitoring team as requested. Staff we spoke with confirmed they had been subject to audits of their practice through direct observation and questioning.

The service had a business continuity plan in place which covered areas such as loss of access to the office, loss of staff, loss of utilities and the action to be taken in each event. The plan also included the prioritising of people who used the service with regards to their individual needs so that they were supported appropriately.

The service had recently produced five 'service development' files that were being used to help identify if the service was meeting all the regulatory requirements in relation to the five key questions CQC ask about services; is the service safe?; is the service effective?; is the service caring?; is the service responsible?; is the service well-led?. Each file contained the relevant CQC Key Line of Enquiry and contained documentation that the service held against each of these.

To support these files, an action plan had been developed in 2015 and was due for review in January 2016. The plan identified each of the Health and Social Care Act

(Regulated Activities) Regulations 2014 which were 'objectives' and these were followed by details of the tasks required to meet the objectives, the success criteria needed to identify success, the time period in which success would be achieved and the resources required. This meant that the service was taking a pro-active approach to identifying if they were meeting the regulations.

The service had recently set up a new 'on-call' rota for out of office hour's telephone contacts, which was supported by an on-call file that recorded all calls received. In addition the file contained a 'priority list' that identified people living in the most vulnerable circumstances which provided instant up to date information for the person who was on-call to ensure an effective response.

The manager told us that one challenge they faced was gaining staff respect and ensuring all staff understood that the management team were supportive. To assist with this the manager endeavoured to explain any instructions or changes in practice to the staff group so that they understood why the request or instruction was being made.