Delta Care Ltd

Delta Care Ltd - Chorley

Inspection report

10 St Thomas's Road
Chorley
Lancashire
PR7 1HR

Tel: 01772559933
Website: www.deltacare-ltd.com

Date of inspection visit:
22 May 2017

Date of publication:
28 June 2017

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?	Requires Improvement
Is the service well-led?	Good

Summary of findings

Overall summary

This inspection took place on 22 May 2017. We gave the service 48 hours' notice of the inspection because it is a domiciliary service and the manager is often out of the office supporting staff. We needed to be sure that they would be in.

Delta Care Ltd – Chorley is a privately owned domiciliary care agency. They are situated in Chorley near the town centre. The agency provides care staff to support people in their own homes. They provide assistance with tasks such as personal care, food preparation, medication administration and household chores. The service supports people around Chorley, South Ribble and surrounding areas. Services are provided to older adults, adults with physical disabilities, adults with memory loss or living with dementia, adults with complex needs and adults with specific conditions such as substance misuse problems. At the time of our inspection the service supported 84 people and employed 26 care staff.

The 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.

This inspection was the first inspection since the service was registered with the Commission on 19 April 2016. During this inspection we found the service was meeting the requirements of the current legislation.

We looked at how the service protected people against bullying, harassment, avoidable harm and abuse. We found there were policies and procedures on safeguarding people. Staff had received up to date training in safeguarding adults and they showed awareness of signs of abuse and what actions to take if they witnessed someone being ill-treated.

Safeguarding incidents had been investigated and documented, showing the support people were getting after incidents. Staff had sought advice from other health and social care professionals where necessary. There were risk assessments which had been undertaken. Plans to minimise or remove risks had been drawn and reviewed in line with the organisation's policy. These were robust and covered specific risks around people's care in a person centred manner.

Lone working and environmental risk assessments were in place to ensure the safety of care staff and people they support. During the inspection we observed staff were visiting people at the planned and agreed times. However we found systems for checking whether staff had visited as planned had not been effectively implemented and monitored.

There was a medicines policy in place and staff had been trained to safely support people with their medicines.

We looked at recruitment processes and found the service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. These had been followed to ensure staff were recruited safely for the protection and wellbeing of people who used the service.
Records we saw and conversations with staff showed the service had adequate care staff to ensure that people's needs were sufficiently met.

We found care planning was done in line with the Mental Capacity Act, 2005. Staff showed awareness of the Mental Capacity Act, 2005 and how to support people who lacked capacity to make particular decisions. They had received mental capacity training.

Majority of the feedback from people about care staff was positive. However; we received mixed views regarding some care staff and the organisation although a significant amount of people told us their experiences had been positive.

People using the service had access to healthcare professionals as required to meet their needs. Staff had received training deemed necessary for their role. Staff competences were checked regularly in various areas of practice including moving and handling, medicine administration and food hygiene. Staff had received supervision through spot checks and supervision meetings at the office. They had also been provided with annual appraisals.

We found that people's care needs were discussed with care commissioners before they started using the service to ensure the service was able to meet their assessed needs. Care plans showed how people and their relatives were involved in discussion around their care. People were encouraged to share their opinions on the quality of care and service being provided. People's nutritional needs were met. Where people's health and well-being were at risk, relevant health care advice had been sought so that people received the treatment and support they needed.

There were established management systems at the service. Senior management had been involved in the day to day management of the service. The registered manager had provided oversight duties they delegated to other staff.

Quality assurance systems were in place and various areas of people's care been audited regularly to identify areas that needed improvement. We found audits had been undertaken of care records, and medicine administration records. There was a business contingency plan to demonstrate how the provider had planned for unexpected eventualities which may have an impact on the delivery of regulated activities.

Surveys we saw showed people felt they received a good service and spoke highly of their staff. Relatives told us the staff were kind, caring and respectful. Professionals we spoke to confirmed this.

We found the service had a policy on how people could raise complaints about their care and treatment.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

This service was safe.

People and their relatives told us they felt safe. Feedback was positive.

Risks to the health, safety and well-being of people who used the service were assessed and plans to minimise the risk had been put in place.

People's medicines had been safely managed. Staff had been trained and competence tested for safe administration of medicines.

Staff had been safely recruited and disciplinary measures were in place.

Is the service effective?

Good

This service was effective.

The rights of people who did not have capacity to consent to their care were protected in line with the MCA principles.

Staff had received training in various areas to ensure they had the necessary skills and knowledge to carry out their roles safely.

People's health needs were met and specialist professionals were involved appropriately.

Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of care staff and felt they were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of people they supported.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People had well written plans of care which included essential details about their needs and outcomes they wanted to achieve.

Communication between people and the office was not always satisfactory and required improvements. The provider had gained the views of people who used the service and their representatives. Care was reviewed regularly and people were involved.

Staff had not always visited as planned and the systems for checking visits had not been effectively implemented and monitored.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their care and treatment. Complaints had been dealt with in line with policies and procedures.

Is the service well-led?

Good

The service was well led.

People felt the service was well managed.

There were adequate governance systems within the service. Management oversight had been provided to care staff and the overall running of the service.

Systems for assessing and monitoring the quality of the service and for seeking people's views and opinions about the running of the service were implemented to improve the care and treatment people received. However improvements were required to monitor that staff were visiting people as planned

Staff told us there was a good culture in the service and were kept up to date with the visions of the service.

Delta Care Ltd - Chorley

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 22 May 2017 and was announced. We gave the service 48 hours' notice of the inspection because it is a domiciliary service and the manager is often out of the office supporting staff. We needed to be sure that they would be in.

The inspection team consisted of two adult social care inspectors, including the lead inspector for the service. We also had on the inspection team two experts by experience, who had experience of caring for someone who used similar services.

Before the inspection, we had asked the provider to complete a Provider Information Return (PIR). 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 took this into account when we inspected the service and when we made the judgements in this report.

Before the inspection we gained feedback from health and social care professionals who worked together with the service. We also reviewed the information we held about the service and the provider. This included safeguarding alerts and statutory notifications sent to us by the registered manager about incidents and events that had occurred at the service. A notification is information about important events which the service is required to send us by law.

During the inspection, we used a number of different methods to help us understand the experiences of people who used the service. We reviewed records of care and management systems used by the service for care delivery. We visited two people in their own homes. We spoke with 19 people and one relative by telephone. We also spoke with the managing director of the service, the registered manager, the deputy manager, two professionals who had visited the service, and six care staff.

We looked at samples of care records of seven people of which four records were pathway tracked.

Pathway tracking is where we look in detail at how people's needs are assessed and care planned whilst they use the service. We also looked at a variety of records relating to management of the service. This included staff duty rosters, four recruitment files, the accident and incident records, policies and procedures, service certificates, minutes of staff meetings, reports from commissioners and the local authority, also quality assurance reports, surveys and action plans, visit plans and visit duration records and medicine records.

Good

Is the service safe?

Our findings

We asked people who used the service whether they felt safe receiving care from the service. All people we spoke with told us they felt safe. Examples of comments included, "Yes I am happy with my regular carer and she does make me feel safe.", "I have no issues whatsoever with safety and the care workers." Similarly, relatives we spoke with told us, "We have no issues with the care workers with regards to safety."

Staff we spoke with were aware of the signs of abuse and discussed the appropriate actions they would take if abuse was suspected. They said, "Any concerns I would inform the office, so that they can inform social services to investigate." Staff told us they had no concerns about the care people received and were aware of the whistleblowing policy (reporting bad practice). They told us they would feel confident reporting any concerns to the registered manager. Comments included, "I have no concerns about the care or the service" and, "I trust that anything I raise with managers would be kept confidential." We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

We saw records of safeguarding enquiries and alerts that had been completed. Evidence we saw demonstrated that care staff were able to report concerns if they suspected people were at risk of exploitation by other people in the community. We saw examples of how management reminded care staff about various types of abuse. In the minutes of one meeting, staff had been reminded that 'cutting care visits short was a form of abuse and fraud and should not be tolerated'. This meant that the service had system in place to address potential safeguarding concerns resulting from reduced visits.

We found that the service had followed safeguarding reporting systems as outlined in their policies and procedures. We looked at information that we had received from people regarding care staff who had been alleged to have acted unprofessionally. We found disciplinary measures; supervision and training had been instigated when there had been a complaint or concern about staff conduct. For example staff who had breached confidentiality, missed care visits or found to have made repeated errors during care delivery.

We looked at how the service protected people against risks of receiving care and treatment. We looked at seven people's care documents. There were risk assessments in people's care files which included risks of malnutrition, falls, medicine misuse, moving and handling, personal care and environmental risk assessments.

Care files we checked demonstrated that people's risks had been assessed, documented and reviewed regularly when there was a change. Risks had been clearly identified and staff had been provided detailed guidance on how they could ensure risks to people were reduced. For example in one person's records staff had been clearly guided to take extra caution when supporting the person to reduce the risk of skin tears. In another example one person had been assessed to be at high risk of falls before they started using the service. Care staff had referred the person to the Occupational Therapist to ensure they received specialist support to minimise the risks. This meant that the service had identified people's risks and put measures in place to minimise them.

Where people required equipment to assist them with their mobility and transferring, staff had clear guidance to check the safety of the equipment and also to ensure the equipment was safe to use.

There was also an 'unable to gain access policy and procedure' also known as a 'No entry policy'. This provided care staff with guidance on what to do in the event of care staff being unable to get an answer or gain access into a person's house when they expected them to be in.

We spoke with people who used the service and relatives about the support they received with their medicines. People said they received their medicines when they needed them with the correct amount of support. We saw one person had requested their visits to be adjusted so that they could have food before their medicines, this had been acted on promptly and the person was satisfied with the outcome. Staff told us and records confirmed they had undertaken the required training in the safe administration of medicines. We saw evidence of competency checks and spot checks. These are visits carried out by management to monitor how staff delivered care in people's homes. This helped to ensure staff had the required knowledge and skills to support people with their medicines safely.

We saw the provider had an up to date and robust policy and procedure to guide staff on the safe administration of medicines.During our observations in people's homes, we saw people were supported to take their medicines safely. Medicine Administration Records (MAR's) confirmed medicines had been administered as prescribed and signed by staff.

We saw that the service had undertaken regular audits of completed MAR sheets. This helped to ensure people's medicine administration was monitored and checked for any gaps. The registered manager told us all MAR sheets were returned to the office and safely stored.

During our visits to people homes, we saw medicines were stored safely to protect people from the risk of misadministration. Where concerns had previously been identified in relation to the administration of medicines, we saw actions had been taken by the provider to ensure any future risks of medicine errors were reduced.

We looked at recruitment processes and found the service had recruitment policies and procedures in place, to help ensure safety in the recruitment of staff. We reviewed the recruitment records of five staff members and found that robust recruitment procedures had been followed. We saw the required character checks had been completed before staff worked at the service and these were recorded. The files also included proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The service employed enough staff to carry out people's visits and keep them safe. Majority of the staff told us they had enough time at each visit to ensure they delivered care safely. Two care staff told us they felt at times they had too much work and had struggled to have a break. We spoke to the registered manager who informed us that staff are advised that if they are unable to manage with the work allocated to them they should return the work to co-ordinators and feel free to speak to the registered manager. People we spoke to informed us staff supported them at a safe pace without feeling rushed.

People told us the service had been reliable and that in the majority of cases staff had visited as planned. They also told us that they saw the same staff unless there was a specific reason for not doing so, such as annual leave or sickness. One person told us, "I have the same regular care workers, I am happy with this." Another person said, "I have a team of three care workers that come."

We asked staff if they felt they had enough time to provide care and travel to their next visits. They told us they were given enough time with people, were given time for travelling and that visits to people did not overlap. People we spoke to told us that staff stayed for the allocated time. However one person said, "She does come on time but she is always rushing doing the work very quickly."

We looked at how the service minimised the risk of infections and found staff had undertaken training in infection prevention and control and food hygiene. There were policies and procedures for the management of risks associated with infections. People told us staff wore their uniforms and gloves and disposed used gloves appropriately.

A business continuity plan had been developed, which helped to ensure continued service in the event of a variety of emergency situations, such as flood, severe weather conditions, flu pandemic or power failure. Staff were aware of actions they needed to take in the event of a medical emergency, such as a person collapsing or if there was no response when they visited someone in the community, who they would have been expected to be at home. There was a lone working policy which provided staff with guidance to promote health, safety and welfare of lone workers. Lone workers are staff who work by themselves without close or direct supervision and in a separate location to the rest of their team or manager.

Good

Is the service effective?

Our findings

People who used the service and relatives we spoke with told us they were confident that staff had the knowledge and skills to meet their needs. Comments included, "Yes they certainly know what they are doing", "Oh yes they are skilled and trained." However some comments we received were mixed, such as "They are good but the office needs to get more care workers to do the job" and "I have two care workers the male care worker is excellent but the female worker has a bad attitude." A relative told us, "There are ones that do need more time and there are ones that are excellent."

We spoke to the registered manager who informed us that they had spoken to the person and we saw records of supervision carried out with the staff in question. The registered manager also advised us they will arrange further support for the staff involved.

Records showed that staff completed an induction programme when they joined the service which included, shadowing experienced care staff to gain experience and staff familiarising themselves with policies such as manual handling, safeguarding vulnerable adults from abuse, confidentiality and whistle blowing. The staff we spoke with told us they had received a thorough induction when they started working at the service. They told us that as part of their induction they had been able to observe experienced staff supporting people, to enable them to become familiar with people's needs before becoming responsible for providing their care. This helped to ensure staff could provide safe, person-centred care which reflected people's needs and preferences.

There was a training plan in place which identified training that had been completed by staff and when further training was scheduled or due. We noted that a significant amount of training had been completed by care staff. Some staff were due to update their training and this had been identified and schedules were in place to ensure these were completed. The manager showed us evidence that first aid training and moving and handling had been arranged for June 2017. Records showed that where training had yet to be arranged, staff had been given training workbooks to complete. The registered manager explained that on completion, staff submitted the workbooks to the training manager and she checked them for accuracy. This helped to ensure that staff were able to meet the needs of people they supported.

We noted that some staff had also completed or were due to start the national vocational qualifications (NVQ two, NVQ three). Staff were also completing the 'Care Certificate'. The care certificate is considered to be best practice for staff members new to the care industry. The (PIR) submitted to the Commission discussed measures the provider had taken to ensure that care staff were adequately skilled. It said, "We have reviewed the induction process and to improve support we have created a new post of mentor. This role will be specific and viewed as a senior care position. New staff will have an extended supported timescale of three months with a named mentor to guide their learning after the care certificate induction and mandatory training."

The service had a training manager who completed the majority of the training for staff members. We saw a specific training room was available in the office.

Records showed that staff received regular supervision. Care staff we spoke with confirmed this to be the case. They had also received on site supervision in the community, which was designed to monitor care staffs conduct whilst they delivered care to people in their homes. We reviewed some staff supervision records and noted that issues discussed included staff performance, standards of care, staff roles and responsibilities and training issues. Additional supervision was also provided when concerns had been identified about staff performance such as medicines errors, time keeping or safeguarding concerns. Staff told us they felt able to raise any concerns during their supervision sessions. The registered manager told us that she planned to complete appraisals with staff in the near future. We saw the schedules for this. This meant that the service had put measures in place to monitor staff performance and offer support where required.

Staff spoken with told us meetings were held, so the staff team could get together and discuss any areas of interest in an open forum. This also allowed for any relevant information to be shared with staff. Records seen confirmed meetings had taken place. We saw that during a recent meeting the importance of good time keeping and staff issues around the rota and safeguarding procedures had been discussed. Guidance and changes to practice had also been shared during the meetings.

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 make particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this in community services such as people receiving services in their homes and supported living are called the Court of Protection authorisation.

We reviewed how the service gained people's consent to care and treatment in line with the MCA. One person told us, "They always ask my consent before they help me with anything." We looked at people's care records and found mental capacity assessments had been completed to identify whether people could make their own decisions regarding their care and treatment. Best interest's processes had been followed where people had been assessed as lacking mental capacity to make specific decisions.

The care staff we spoke with demonstrated an understanding of the legislation as laid down by the Mental Capacity Act (MCA) 2005. Staff spoken with demonstrated a good awareness of the Mental Capacity code of practice and confirmed they had received training in these areas.

We looked at how people's nutrition was managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. Systems and processes for monitoring people's nutritional needs were in place. People's records showed people's preferences and risks associated with poor nutrition had been identified and specialist professionals had been involved where appropriate. The PIR submitted to the Commission discussed measures the provider had taken to ensure that care staff were adequately skilled to support people with their nutrition. They told us, "One of our carers will be conducting a training workshop on how to cook healthy food for service users and for the general wellbeing of our staff."

People's healthcare needs were considered as part of the care planning process. We noted assessments had been completed on physical and mental health and there was a detailed section in each person's care plan covering people's medical conditions. This helped staff to recognise any signs of deteriorating health. There were links with the local primary health services and professionals such as local doctors and District Nurses.

Good

Is the service caring?

Our findings

We received numerous positive comments about the care staff and the service delivered to people. Comments included, "The care workers are very nice, they always do what I say or help me when I need them to", "I have a good relationship with my care worker, she is like a friend to me" and "The care workers themselves are brilliant, just brilliant." One relative said, "We have good ones and we have bad ones. We have filled in a questionnaire for the company. Do not have much more to say." However one person had a mixed view and told us, "The male care worker is brilliant, very caring, he listens to me and he tries to make me as independent as possible. The female carer has a bad attitude towards me she is always rushing; she does not really speak much to me. I do not like telling tales though."

We discussed this with the registered manager who assured us they would discuss people's feedback in the next team meeting.

Staff spoken with and the registered manager had a sound knowledge and understanding of the needs of people they cared for. Staff members told us how they enjoyed working at the service. Comments from staff included, "We care for people like they are our family really" and "I like my job and I enjoy supporting people."

We considered how people's dignity was maintained and promoted. We noted people's daily records and care plans had been written in a way that took consideration of their choices and preferences. People had been asked about their likes and dislikes and this had been included in their daily support. Staff we spoke with talked about people in a respectful, confidential and friendly way.

Daily records were completed by care staff and were written with compassion and respect. All staff had been instructed on maintaining confidentiality of information and gave us examples to demonstrate that they understood the procedural guidance. We also saw evidence of actions taken where staff had been found to have breached confidentiality. People's records were stored securely. This meant people using the service could be confident their right to privacy was respected with their personal information kept in a confidential manner.

Staff we spoke with showed a clear understanding of the measures in place to ensure a person's privacy and dignity was respected and gave appropriate examples. They told us they understood that their place of work was someone else's home and had to be respectful. They knocked before entering even when they had used a 'key safe' to enter the house. A key safe system is a system where a key is stored in a secure box outside of the property.

There was information available about advocacy. Advocates support people to access information and make informed choices about various areas in their lives. Relatives that we spoke with informed us that they had been more involved in the care of their family members and that this had improved the quality of the care they received. The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people using

the service.

Requires Improvement

Is the service responsive?

Our findings

We received mixed feedback from people using the service and their relatives. Comments included, "The office staff are brilliant", "It has got better now, they did have a problem with communication this is getting better", "I have been with this company for three years and I have never had course to complain", "I could not recommend the office, the girls are brilliant but the office have a 'can't be bothered attitude'", "Communication could be better" and "I could not really recommend the office as they do not allocate me a person on the rota until it's too late."

We spoke to the registered manager and the managing director regarding the feedback from people especially around communication. The registered manager informed us that it is an issue that they had identified and had recently arranged training with the office staff to improve their customer service. They also informed us that they had been aware of the concerns regarding the phone system at the service and they have reported this to the phone service provider. They added that 'when people were phoning they did not get an 'engaged tone' or 'call waiting notification' if the lines are busy. Therefore, at times if all office staff are on calls and another phone call came through it may just ring giving the impression that no one is answering'.

After the inspection the operations director informed us that they were speaking with their telephone service provider to get a notification so people calling understand that people are not ignoring them, they are busy on other calls. They also informed us that the registered manager spoke to the person who informed us that a member of staff appeared to be in rush during visits and the matter was resolved.

We looked at how the service provided personalised care that was responsive to people's needs. We found assessments had been written in a person centred manner and were detailed. Care plans contained people's identified needs, the outcomes they wanted to achieve and guidance to staff on what to do on arrival to people's houses and the order in which people preferred their care to be delivered.

We looked at what arrangements the service had in place to ensure people received care that had been appropriately assessed, planned and reviewed. We looked at seven people's care files. All seven files contained assessments also known as support plans. It was evident that a full assessment of people's needs had been completed before a decision had been made about whether the service could meet that person's needs. Additional assessments were also evident in some of the files we looked at, for example assessments completed by the Local Authority. This helped to provide a more detailed and holistic assessment of people's needs.

We also noted that people had been involved in their assessment and where appropriate, the service sought support from their family members. One family member said, "They visited us and reviewed the care plan with me present." Daily reports provided evidence to show people had received care and support in line with their care plan. We noted that records were detailed and people's needs were described in respectful and sensitive terms.

We noted procedures were in place for the monitoring and review of care plans. Care plan reviews were carried out regularly and wherever possible people using the service and their families, if appropriate, were involved.

We looked at whether care visits had been effectively planned and delivered in line with people's needs. We found care staff had visited as planned in the majority of the cases and stayed the duration of the allocated time. People told us the service had been reliable and that in majority of the cases staff had visited as planned. They also told us that they saw the same staff unless there was a specific reason for not doing so, such as annual leave or sickness. One person told us, "I have the same regular care workers, I am happy with this." Another person said, "I have a team of three care workers that come."

We looked at the policies and procedures that the provider used to check if staff were staying the allocated time and visiting as planned. There was a log in and log out system for which staff used to demonstrate the time they arrived and the time they would have left people's house. We found that staff were staying the duration however the systems had not been effectively implemented because staff did not always log in and out. Two visit records and staff rotas that we looked at demonstrated that two care staff had visited half an hour late and half an hour early at times. This was not in line with the staff's allocated rotas and people's care plans. This had not been identified through the call logging system which meant that people had not received their care as planned. This had an impact on adults who lived on their own and could not raise concerns with the service.

We spoke to the registered manager regarding this and they informed us that there was a system for monitoring staff to ensure they visited as planned and followed the rotas given. They added that another member of the management team had been tasked with managing staff who had not been logging their visit effectively and may not have audited the call records consistently. We discussed the importance of auditing visit records formally and regularly to ensure that people were receiving the care they were assessed for at the agreed times. We saw records demonstrating that the registered manager had spoken to staff on several occasions warning them against cutting visits short.

We asked staff if they felt they had enough time to provide care and travel to their next visits. They told us they were given enough time with people, were given time for travelling and that visits to people did not overlap. People we spoke to told us that staff stayed for the allocated time. However one person said, "She does come on time but she is always rushing doing the work very quickly." We shared the feedback with registered manager who assured us that this would be addressed with all staff during the next meeting.

The service had a complaints procedure in place. The procedure provided directions on making a complaint and how it would be managed. This included timescales for responses. We saw complaints and compliments guidance was provided to people when they joined the service and was easily accessible. Staff we spoke with confirmed they knew what action to take should someone in their care, or a relative approached them with a complaint. We also saw evidence of complaints that had been received and how they had been dealt with. Evidence we saw showed that the registered manager, the operations manager and at times the director visited people if they had raised a complaint to try and resolve the issues. Complaints had been dealt with in line with the organisations' policy. This meant that people could be assured that their concerns had been received.

People we spoke with confirmed they were aware of the complaints procedure and how to access any information around making a complaint. They told us they were confident should they have any issues that these would be dealt with appropriately.

Good

Is the service well-led?

Our findings

We received positive feedback about the management and leadership of the service. People told us, "The Company is very good I cannot grumble", "Very good company, I could recommend them" and "The office staff are brilliant." Staff were complimentary about the registered manager and the management team. They told us, "[Name] is great as a manager." They told us they were supported to develop their skills to undertake their jobs effectively and felt they could contribute to the development of the service.

A professional told us, "I have found management to be knowledgeable and very committed to the individuals they support and also very supportive of their staff."

The service was led by a manager who is registered with the Care Quality Commission. The registered manager had responsibility for the day to day operation of the service. There was a clear leadership structure in place within the organisation. All staff we spoke with were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any emergency or concern. There were up to date policies and procedures relating to the running of the service. Staff were made aware of the policies at the time of their induction and when new changes came into place.

We spoke with the registered manager about the daily operations of the service. It was clear they understood their roles and responsibilities and had an understanding of the operation of the service. This included what was working well, areas for improvement and plans for the future. They were supported in their role by the director, operations manager, deputy manager, training manager and care coordinators.

The senior management from the organisation were actively involved in ensuring the service was compliant with regulations and delivering good quality care. We found evidence to demonstrate that there was management oversight from the registered manager. For example, staff with delegated tasks had been supervised by the registered manager and discussions had been undertaken on what was expected of the staff and how progress was going to be monitored. Staff had been made aware who they were accountable to. This meant that the service had arrangements in place to ensure staff had clear guidance and lines of accountability.

There were quality assurance systems and tools in place. We saw regular surveys had been carried out to seek people's views and opinions about the care they received. People were also asked to share their views about care staff and the feedback was positive. Where concerns had been raised in the questionnaires, action was taken immediately.

We found the registered manager and reviewing officers had visited people to review their care and also seek their views on the care they received. The registered manager told us and records confirmed how they monitored the quality of service. These included audits of medicines administration records, competence visits, and people's daily records. Spot checks had been undertaken to observe staff's competency on a regular basis. These were in place to check that staff were punctual, stayed for the correct amount of time allocated and the people supported were happy with the service.

There was evidence of the measures taken by the provider as a result of the findings from the audits. However; we found improvements were required in relation to systems and processes for auditing visit records to ensure the provider assured themselves that people had received their care visits as planned. The records had not always been audited and we found issues that could have been picked up by regular routine audits.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was robust. We found meetings, memos and modern technologies were used to keep staff informed of people's daily needs and any changes to people's care. Information was clearly written in people's daily records showing what care was provided and anything that needed to be done on the next visit.

We also found a handover system was in place to ensure information relating to people's care was shared between care staff and staff located in the office. For example information relating to changes in people's care visits. However concerns had been raised regarding the telephone communication systems in the service and communication with office staff. We shared the concerns with the registered manager and the operations manager who assured us they had been aware of this and were working to resolve the concerns.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and related to people who used the service. We found the registered provider had fulfilled their regulatory responsibilities and statutory notifications were being submitted to the Commission. A notification is information about important events which the service is required to send us by law.

We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as local health care agencies and local commissioning group, pharmacies, and local GPs. Challenges associated with working with other agencies had been identified and the service had engaged other services effectively to ensure safe and effective provision of care service. For example challenges associated with people moving from hospitals into the community.