Carewatch Care Services Limited

Carewatch (Wigan)

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

Summary of findings

Overall summary

We carried out an announced inspection of Carewatch (Wigan) on 05, 06 and 07 July 2017. The service was newly registered in January 2016 and this was the first time it had been inspected.

Carewatch (Wigan) are a large domiciliary care service providing care and support to people with a range of differing needs within their own home. The service is managed from an office in Standish and is a member of the local authorities 'Ethical Community Services Framework', being awarded the contract for provision of care in Pemberton and Wigan Central. At the time of the inspection 443 people were using the service.

At the time of the inspection there was a registered manger in post. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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 using the service and their relatives told us they felt safe as a result of the care and support provided by Carewatch (Wigan). We saw the service had appropriate safeguarding policies and procedures in place. Staff had all received training in safeguarding vulnerable adults, which was refreshed annually and were able to demonstrate a good understanding of how to report both safeguarding and whistleblowing concerns. Staff were confident any concerns raised would be actioned by senior staff.

Both people using the service and staff members we spoke with felt enough staff were employed to meet people's needs. People spoke positively about the continuity of care and stated that overall staff arrived on time and stayed as long as was needed to provide the care required. Staff felt their rota was manageable and in most instances appropriate travel time had been factored in. The service used systems to ensure staffing levels were appropriate to meet people needs and calls were logged and monitored electronically to ensure consistency.

We saw there was both a policy and systems in place to ensure safe medicines management was maintained. People we spoke with confirmed they received appropriate support to ensure medicines were taken when required and as prescribed. We saw the service carried out audits of a selection of medicine administration record (MAR) charts each month to ensure medicines had been administered and documentation completed correctly. All staff administering medicines had received training and had their competency assessed.

We saw that robust recruitment procedures were in place to ensure staff working for the service met the required standards. This involved all staff having a Disclosure and Baring Service (DBS) check, at least two references and full work history documented.

Staff were complimentary about both induction and refresher training and confirmed they received an appropriate level of training to carry out their role effectively. We saw all staff completed a comprehensive

induction training programme followed by a variable period of time shadowing experienced care staff, before being allowed to work independently with people who used the service. We saw the service had systems in place to ensure that staff received regular refresher training to ensure their skills and knowledge remained up to date.

People we spoke with told us the staff were kind and caring and treated them with dignity and respect. People had been involved in discussing their care and how they wanted to be supported, with clear guidance in place within care files to ensure staff knew how to meet their needs and wishes. Staff were knowledgeable about the importance of promoting people's independence and how to go about doing so.

We looked at 16 care plans, which were comprehensive and person centred containing detailed information about each person. The care plans also contained risk assessments, which helped to ensure people's safety was maintained. We saw a process was in place for reviewing care plans, which was done both in person and via telephone calls and people were also asked for their opinions of the service and care received through completion of bi-monthly questionnaires.

People using the service knew how to complain, with information provided in the care files they kept in their homes. People we spoke with who had raised a complaint reported these had been dealt with quickly and effectively. The service had a robust complaints policies and procedures in place, with all issues and outcomes documented in detail.

Each staff member we spoke with said they enjoyed their job and felt the service was well run. The completion of regular supervision and team meetings, meant they felt supported in their roles and had the opportunity to discuss issues relevant to them.

We saw that there were a range of systems and procedures in place to monitor the quality of the service. Audits were carried out both internally by the registered manager and quality performance officers and externally by the provider and their representatives. A quality improvement plan was in place to ensure any issues or areas of non-compliance were being addressed. We saw this was updated regularly to reflect progress made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

The service had systems and procedures in place which sought to protect people from harm and keep them safe. Safeguarding policies and procedures were in place and staff were aware of the process.

Staffing levels were appropriate to meet the needs of people who received support.

The service had robust recruitment procedures in place, to prevent unsuitable people from working with vulnerable groups.

People we spoke with told us that they received their medicines safely and when necessary.

Is the service effective?

Good

The service was effective.

Staff reported receiving enough training to carry out their roles successfully and were provided with regular support and supervision.

Care plans demonstrated that people had been involved in discussions around their care and support and their consent sought.

The service was working within the legal requirements of the Mental Capacity Act (2005) (MCA).

The service worked closely with other professional and agencies to ensure people's health needs were being met.

Is the service caring?

Good

The service was caring.

People told us staff were kind and caring and respected their privacy and dignity.

Staff were aware of the importance of promoting independence and providing choice and able to provide examples of how they ensured this was completed.

Compliments received by the service highlighted the caring approach taken by staff.

Is the service responsive?

Good

The service was responsive.

Care plans were person-centred and individualised with information about what was important to people and how they wanted to be supported.

Detailed guidance was in place for staff within care files to ensure they could meet people's needs, wishes and preferences.

The service had a detailed complaints procedure in place and all complaints received had been well managed. Each person using the service was provided with details of how to raise a complaint and who to speak with

Is the service well-led?

Good

The service was well-led.

Audits and monitoring tools were in place and used regularly to assess the quality of the service, with action points generated and details of progress clearly documented.

Both the people using the service and staff working there felt the service was well-led and managed and staff reported feeling supported in their roles and confident in being listened to if they raised issues or concerns.

Regular team meetings were held for all staff roles, to ensure information was circulated and staff made aware of changes to practice or areas where improvement was required

Carewatch (Wigan)

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.

The inspection took place on 05, 06 and 07 July 2017 and was announced. We gave the service 48 hours' notice, as the location provides a domiciliary care service and we needed to be sure the manager would be in the office to facilitate the inspection, as well as allowing time for the arrangement of staff interviews, so as not to disrupt the provision of care.

The inspection team consisted of two adult social care inspectors from the Care Quality Commission (CQC) on the first day of inspection. The remaining two days of the inspection were carried out by one adult social care inspector. The inspection was also supported by two Experts by Experience, who completed telephone interviews with people using the service on 06 July 2017. An Expert by Experience is a person who has experience of using or caring for someone who uses health and/or social care services.

Prior to the inspection the service completed a Provider Information Return (PIR), which is a form that asks the provider to give some key information about the service. We also reviewed all the information we held about the service including statutory notifications and safeguarding referrals and contacted external professionals from Wigan Council.

As part of the inspection we spoke with the registered manager, quality improvement service manager, quality monitoring officer, recruitment officer, a care coordinator and 12 care staff. We also spoke with 26 people who used the service and five relatives.

We looked at 16 care files, 17 staff files and 12 Medication Administration Record (MAR) charts. We also reviewed other records held by the service including audits, training documentation, care notes and safety documentation.

Good

Is the service safe?

Our findings

Both people using the service and the relatives we spoke with told us they felt safe as a result of the care and support provided by Carewatch (Wigan). One person said, "Oh yes, I do feel safe." Another stated, "Safety is very important for me, I do feel safe with my care workers." A third told us, "They are lovely the girls.....I do feel safe with them." Whilst relatives comments included, "[Name] is very safe with the care workers," and "Yes, no problems in that area."

The service had appropriate systems and procedures in place which sought to protect people who used the service from abuse. The service maintained a safeguarding file which contained the company policy along with the local authorities' policy, procedures and tier guidance. We saw a checklist was in place which had been used for all safeguarding investigations to ensure all necessary steps and processes had been completed. A monitoring log had also been used to document any referrals, which included the date of referral, who was involved, nature of the safeguarding, the action taken, any outcomes and date closed. We noted this had been completed in detail with all follow up actions completed.

Staff we spoke with displayed a sound understanding of the safeguarding process and their responsibility for reporting any concerns. All staff confirmed they had received training in this area, which was refreshed annually. One told us, "We do training in safeguarding every 12 months. I would report any issues directly to the office." A second said, "Yes, I completed training which covered adults and children. I know what to do and who to report any concerns to." Whilst a third stated, "I know what to look out for and the different types of abuse and would report any concerns to the office."

The service had a whistleblowing policy in place which told staff what action to take if they had any concerns. Staff also told us the policy and procedure was covered in training and the details of a dedicated phone number and email address they could contact were located in the staff handbook and given to them when they commenced employment.

We looked at infection control practices within the service. We asked the people and relatives we spoke with if staff wore personal protective equipment when necessary. Everyone told us they had no issues with hygiene, with gloves and aprons being consistently worn as required.

We looked at the care and support records of people who used the service and found these were comprehensive, well organised and easy to follow and included range of risk assessments to keep people safe from harm. These included areas such as skin breakdown, nutrition, hydration and moving and handling. Additionally there was a 'safe working risk assessment and management plan' document in use which considered issues relating to the home environment of the person receiving care and support, such as fire safety, lighting, temperature, tripping hazards and the condition of external pathways and steps. This meant staff considered any environmental risks to the person receiving care and support or to themselves at each home visit. Each risk assessment had a corresponding form that identified the specific risk or hazard, the existing control measures and further control measures required to reduce any potential risk.

When reviewing care files we did note three instances when either some information on the risk assessment was not up to date, or the care file indicated an assessment should be in place but we were unable to locate this, for example the service had indicated a person was at an increased risk of contracting a pressure area and therefore required a tissue viability risk assessment to be completed, however one had not been done. Another person's manual handling risk assessment had not been updated following a change in circumstances, and although the service had requested the local authority complete this prior to the change, the information in the care file was still incorrect. In this instance we did see that staff supporting this person, had been made aware of the changes and were providing care in line with the person's needs.

We looked at how the service managed accidents and incidents. There was an appropriate, up to date accident and incident policy and procedure in place which was last reviewed in December 2016. This was supported by a critical incident policy. Details of any accidents and incidents were recorded appropriately, including any remedial action required to reduce the risk of any future potential harm and a central monitoring log sheet was used to track all events.

An accident/incident tracker form was used which included; the name of the person involved in the incident; the nature of the incident and the action taken. At the end of each month, data regarding accidents/incidents was reported to the governance board. We saw that accident/incident forms were completed with a good level of detail and records also contained a copy of the Statutory Notification sent to the Commission, where applicable. This demonstrated accidents and incidents were being managed appropriately.

We looked at 17 staff personnel files to understand the process of recruitment. We saw there were robust 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 and a health declaration form and equal opportunities monitoring form had been completed for each new staff member. This showed us that staff had been recruited safely.

We asked people using the service whether they received continuity of care and if staff supporting them arrived on time and stayed as long as commissioned. One person told us, "In the main they are on time, we give them a half hour window and they come within this time, do the job and go. It does seem they have time constraints." Another said, "Pretty much so, they are good, they do not rush and always ask if there is anything else I need before they leave." A third stated, "It has improved a lot recently, sometimes people never came but now I have a regular girl and she's pretty much on time." A fourth said to us, "The girls come on time, it's usually [name] until the weekend then it's someone else." A relative stated, "Oh yes, they are on time, only odd occasion when there has been an emergency they are late." A second told us, "Had some trouble with them coming too early at teatime. She has her lunch at 1.00pm and then staff might be back at 3.00pm to give her tea, which is too early, but that's the only issue."

In terms of continuity, people spoke positively, reporting they usually had the same team of care staff supporting them, except when staff were on holiday, when necessary changes were made which they accepted. Comments included, "We have a team of six to eight care workers, we are happy with them all", "Yes, I have the same care workers" and "Yes, more or less, only during holidays and days off do the care staff change, but there are no issues for my relative with this."

We asked staff for their opinions of staffing levels at the service and management of their rotas. One told us,

"I cover the Pemberton area, all seems to run well. Rotas are well organised and I have enough time to get to calls and spend with people." A second said, "No problems with staffing, my rota is fine. If I need to stay a bit longer with someone, then I do, no problem with this." A third stated, "Staffing is okay, some calls are too long and some not long enough, but this is not down to the office, the times are what has been commissioned." However some staff raised minor concerns such as, "Weekends are a nightmare as half the staff are rested, my rota is manageable because in my view it takes as long as it takes, if I'm running behind I will ring up and let the office know." Another said, "Only issue I find is travelling between places. They don't seem to consider traffic conditions in the travel time. These could have more leeway, especially when travelling in middle of Wigan at busy times."

We looked at how the service ensured staffing levels were appropriate to meet people's needs and calls were made on time. The service used Staffplan roster to plan and organise rotas and care visits based on people's needs and also monitored calls. Staff checked in and out of each property electronically and this was monitored via the roster system. A care co-ordinator told us the service allowed half an hour either side of allocated time for staff to arrive, if the time exceeds this either way an alert was triggered on the system. If this became a regular pattern, they would contact the carer to ask for a rationale. If a staff member forgot to sign in this was also picked up by the roster system and logged as 'call not confirmed'. An investigation would commence and if the call was missed, it would be recorded as such on the system with a separate log and the local authority notified.

We looked at the rotas for 12 different care staff and noted call times where reflective of people's needs with varying travel time included between each call, depending on the distance travelled. Even for houses on the same street, we saw up to three minutes travel time had been allocated. The service also had a 'call availability' document in place for each area covered, which listed staff requirements and when a gap appeared this was used to trigger recruitment, to ensure staffing numbers were sufficient to meet people's needs.

People using the service told us staff supported them effectively with their medicines, whether this was through prompts and reminders to take or via actual administration. One person said, "They do my pills alright." Another told us, "They don't give me my pills, but they make sure that I take them." A third stated, "They do my medicines, no problem. It's safer for them to do it." A relative said to us, "We are happy that [person] is safe, she does her medicines herself, but they do remind her."

Staff we spoke with confirmed they had received training in medicines management, which was refreshed annually and specialist training was also provided when required. They also told us spot checks and competency assessments were completed by the quality monitoring officers. One staff said, "Had training in medicines which is covered again in refresher training. My competency was checked by the QMO." Another stated, "We get full training in this and then observations are completed." A third told us, "Yes, done training. They tell you about MAR charts, what people are taking, why and how to fill in the documentation. I felt confident to support people with their medicines after I had done it."

We looked at how the service managed people's medicines. Care files contained guidance about whether the person took medicine and what support they wanted; for example ordering, collecting, prompting or administering and a list of current medicines prescribed and times of administration. Care files also contained information about 'as required' (PRN) medicines, to support staff in administrating these appropriately.

We looked at the Medicine Administration Record (MAR) charts for 12 different people. The service used their own MAR charts, onto which each person's medicines had been typed. We saw these contained the person's

name, date of birth and allergy information, as well as the medication name, strength, dose and route. We did see for people whose medicines were pre-packaged and provided in a 'blister pack', the chart merely stated 'blister pack' rather than listing each individual medicine. We were told this was because the care file contained a list of current medications. Each MAR chart also had a front sheet, which staff supporting the person signed, initialled and dated. This would help track who had administered medicine on a particular day. The service utilised a coding system, which was recorded onto the MAR chart next to the time of administration and the staff member's initials. The code A1 indicated the person had capacity, but medicine was administered to them, A2 indicated the person lacked capacity and medicine was administered to them, AS indicated medicine was administered by special technique, such as via PEG , P indicated the person required only a prompt and O was for any other situation, which was to be recorded on the rear of the sheet.

We asked the registered manager about the procedures in place to identify medication errors. We were told carers would report any discrepancies to the office, which would be logged and trigger an investigation. There was a clear process in place which involved contacting the staff member responsible to discuss and also sending them a memo, if further errors occurred providing them with re-training followed by disciplinary action. The service also completed an audit of MAR charts on a monthly basis. Previously all MAR charts had been checked as part of this process, which meant all recording issues and other errors had been identified, however due to the number of people who had transferred to the service as part of the Ethical Framework process, the service now completed a random check of just 10% each month; as per company policy, until such time as home visits with all new people to the service had been carried out. We were told the service would revert back to checking all MAR charts once this process had been completed. During our review of MAR charts, we saw the audit had been effective in identifying errors such as missed signatures and incorrect use of codes, however we also noted a number of issues with missed signatures, codes not being used or used incorrectly on MAR charts which had not been audited, which meant these issues had not been identified by the service.

Good

Is the service effective?

Our findings

We asked people who used the service if they thought staff were well trained. One person told us, "Yes, they seem to know what they are doing." Another stated, "Yes, they are smashing." A third said, "On the whole they know what to do." Relatives spoken with also felt the staff were competent and provided an effective service. One said, "Yes, they are trained. My relative has no issues with the skills or training." Another told us, "They all seem well trained." However some people we spoke with had minor complaints, one person said, "They have the ability and the care workers are good people, but at times they don't put the frying pan back in the right place or always wipe down the worktops. As I am blind, these things mean a lot to me." People also commented on their regular carer being very good, but felt other staff who supported them were not as competent. One person said, "My regular carer knows what she is doing, some of the others you have to tell them what to do."

Staff told us they felt they had received sufficient training to undertake their role competently. They also spoke highly of the person who completed the training. One staff member told us, "I had a period of five days induction at the start and did lots of training like health and safety, moving and handling and safeguarding. I read policies and procedures and did some shadowing for about five days and then I was observed and signed-off as being competent. I think the process was very thorough and I felt confident at the end of it. I've since done training in PEG care and now I'm doing NVQ level two in health and social care." Another said, "Training here is good, I am due to do some more in August. We definitely get enough and it is very enjoyable." A third stated, "I loved it. [Trainer's name] made it really fun and gave us enough knowledge to feel confident when training had finished." A fourth said, "When I did induction it lasted three days, but is now a week. After training I went out shadowing for five days, was definitely enough to help me do the job."

We looked at the process of induction for new staff members. We saw that induction took place over a five day period and detailed records of each staff members' induction was kept on their personnel file. Staff members were also given a learning and development passport, which contained information about the training provided as well as being used as a record to detail training sessions completed throughout employment. Induction training included both practical and theory based sessions, including manual handling, equality and diversity, working in a person-centred way, end of life care awareness, fluids and nutrition, first aid and the safe handling of medicines. Induction training was the first step of the service's 'Footsteps' programme, which was a twelve week, eight step process completed by all new care staff, to ensure they were fully supported in the early stages of employment. The programme included completion of induction training, shadowing of experienced staff, having practice observed, completion of a one to one, meeting the registered manager and completing a supervision meeting. There was also an 'induction checklist' sheet in place which was used to audit the progress of new staff relative to the induction process, an 'induction field shadowing form' and 'end of probationary period review' form. This meant the staff induction programme for new staff was robust.

We saw office staff had completed a 'train the trainer' course in PEG feeding and completed person specific training in Stoma care, with anyone in hospital with a Stoma in situ, due to be supported by the service, which they then cascaded to the care staff, to ensure staff had the skills and knowledge to meet people's

needs.

We saw staff were given a copy of the organisation's policies and procedures which were available electronically or in paper format and staff knowledge of these policies and procedures was tested out at supervision meetings and as part of the process of induction. This meant staff were clear about the standards expected by the service and how the service expected them to carry out their role in providing safe care to people in their own homes.

The service had a training matrix in place, which detailed the training completed by each staff member. The matrix was colour coded to indicate if staffs training was in date (green), due to expire (amber) or had expired (red). We noted over 95% of staff were up to date with all training sessions, with the remainder booked onto the next available sessions.

Staff received supervision and appraisal from their manager and the service kept a record of all staff supervisions that had previously taken place. These processes gave staff an opportunity to discuss their performance and identify any further training they required. We found that staff were actively encouraged to share their views and opinions through the mechanism of supervision. The service had an up to date supervision policy and procedure, which stated staff would receive four 'supervisions' per year as per national minimum standards. The four were made up of at least one office based meeting, field based observation, annual appraisal and attendance at team meeting.
Staff told us they received supervisions every three months in addition to an annual appraisal. We checked records to verify this. One staff member said, "I find this process useful as I can discuss face to face with my line manager any issues I have." Another stated, "We get brought into the office when due, last one was a few months ago. I was able to bring stuff up, I find them useful." A third told us, "We have an annual appraisal, supervision every three months and get spot checked. We get letters inviting us to meetings."

Records of supervisions were kept in staff personnel files and we saw discussion topics included: actions from the last supervision meeting; training completed; support from the manager; any concerns about people using the service; training and workload. Meeting completion was monitored via a matrix, which ensured all staff had completed the required minimum of four meetings per year.

We looked at the way the service managed consent and found that before any care and support was provided, consent was obtained from the person who used the service or their representative. We were able to verify this by checking people's care files. Care files contained a consent to care and treatment form that was signed by the person or their representative. If it was suspected that a person may not have the capacity to agree to care and treatment a mental capacity assessment was carried out to determine this. We did note that despite indicating capacity assessments had been completed, these were not located in the people's care files we viewed. The consent document also stated if a person lacks capacity, a best interest decision must be made. In one person's file, whilst the tick box on the document had been checked, to indicate the process had been completed, we found no actual evidence to confirm a best interest meeting had been held and decision made.

All the people using the service we spoke with, told us staff sought their consent before providing care. Comments included, "They always ask me what I want done," and "Yes, they ask me all the time." Staff also displayed a good understanding of the importance of gaining consent and how to go about doing so. One said, "I have a chat with people I support and ask them." Another stated, "Ask them, give people choices with everything. Even if they haven't got capacity, I will still ask before doing anything."

Support provided to people to assist with nutrition and hydration varied depending on individual needs.

Staff were knowledgeable about the people they supported and their nutritional needs, including people who had special dietary requirements. One said, "We ensure we provide meals and drinks as required. If people refuse at the time, I always try to leave something for them in case they change their mind once I am gone. If I have any concerns about a person's diet for instance, I would report this to the office." Another told us, "One person I support has to have their drinks thickened. Everything on how to do this is clearly written down, down to the amount of liquid in millilitres." A third stated, "We offer people different foods, to ensure a balanced diet. Some people have fluid and bowel charts in place, so we can monitor input and output." Staff also told us they recorded on daily notes exactly what people had eaten and drank, rather than just put 'had lunch', in order to help with monitoring people's diet. We looked at a selection of care notes for 10 people which evidenced this was completed as described.

People using the service provided mixed feedback regarding the support they received in this area. One said, "I choose my food and they prepare it just like I want it." Another said, "They do my meals for me in the microwave, that's alright with me." However a third person said, "They make my breakfast and do my tea. I can't abide frozen meals, so I just get sandwiches and beans on toast, but it does for me." A fourth person stated, "They say they will only do ready meals or butties, but I don't want to live like that, so my daughter leaves me meals." Despite all but one of the people we spoke with who were supported with nutrition and hydration indicating the majority of their meals were prepared using the microwave, the daily notes we looked at made reference to a wide variety of meals being produced using differing cooking methods, including roasted meat and poultry, boiled potatoes and vegetables.

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.

We checked whether the service was working within the principles of the MCA. We found the service had an up to date MCA policy and procedures in place and staff had all received training in this area. One told us, "Yes, I have heard of the MCA and done training in it. We have got a little card that was sent to us about capacity. People's capacity can change, such as when they're unwell." Another said, "Yes, we have covered this in training. You have to assume someone has capacity until it is proven they haven't." A third stated, "Everybody is different, you can't say they haven't got capacity until it is proven. Capacity can change day by day."

Care files contained a 'making decisions' section which detailed if a capacity assessment had been completed, if the person had a Lasting Power of Attorney (LPA), DNR/DNACPR and advanced care plan in place. A log was also in place for staff to keep a record of any simple best interest decisions they had made when supporting people with fluctuating capacity.

Within the 16 care files we viewed, we saw evidence of involvement from medical and other professionals which had been arranged or co-ordinated by the service. This included speech and language specialists (SaLT) and manual handling assessors from the local authority. In all but two files, up to date guidance was place, with evidence seen of requests for either a further assessment or copy of the latest report requested for the remaining two files.

Good

Is the service caring?

Our findings

People who used the service and their relatives told us care staff were kind, caring and helpful. One person said, "I am extremely happy with my care workers, they are very kind to me." A second stated, "The care workers are wonderful, I do not doubt their ability at all, I think they work under a lot of pressure." A third told us, "The care workers are very kind, nice and extremely helpful." A relative said, "It's brilliant, the carer is very good indeed, my [relative] likes her." A second added, "[Relative] is very satisfied with the staff, they are very nice to her."

Some people indicated they would like care staff to spend more time with them, so they could chat for longer, but appreciated this wasn't always feasible. One said, "They are caring but it would be nice if they could spend some more minutes to chat with me, but it's not their fault as they are busy and have other calls."

Staff members displayed a clear understanding of the ways in which dignity and respect could be maintained. One told us, "I never strip a person to wash them, I use a towel and always do the top half first. Make sure I ask them throughout if they are okay and if they are comfortable." A second said, "Cover people with a towel, make sure curtains are closed, ensure you treat people the same way you would want to be treated." Whilst a third stated, "It's about respecting people's privacy with toileting and personal care."

We asked people if they felt treated with dignity and respect by the care staff who supported them, everyone we spoke with told us they did. One person said, Yes, it's excellent. My girls are wonderful." Another stated, "Yes, they are very polite." A third told us, "It's very good, the girls are very nice, very polite." Whilst a fourth added, "I have no grumbles, they talk to me, the do the tasks but always address me."

The staff we spoke with displayed an awareness and understanding of how to promote people's independence and the importance of providing choice. One told us, "Allow people to do for themselves what they are able to. Ask what can they do and to ask for help if needed." A second said, "Respect their wishes. If people don't want to do something, you can't make them. Just document their choice and support as best you can." A third stated, " I ask people would they like help and allow them to make their own choices." Whilst a fourth added, "I get people to do as much for themselves as they can. I ask what would they like to do and then help when asked or where I can see they can't manage something." People using the service confirmed staff promoted their independence and offered them choice, one person said to us, "They speak to me, they always ask me if I need anything before they go, this means a lot to me."

We saw people had been involved in discussions about their care plans and how they wished to be cared for. Care files contained clear guidance about each person's needs and wishes, which was commented on by staff. One said, "The care plans are very detailed, they tell you what people want and how to care for them step by step." A second stated, "Care files have a lot of information in about the person. When I arrive at a house, I read the file first, to make sure I know what to do." A third stated, "Care plans tell you pretty much everything you need to know about how to care for each person."

Compliments received by the service highlighted the caring approach taken by staff and the positive relationships they had established to enable people's needs to be met. The service logged all compliments received and also kept a file in reception containing a selection, of staff and visitors to read. We noted 29 compliments had been received so far this year. Comments included, 'We would like to send our grateful thanks to all the carers who attended our dad. He was provided with extremely professional and caring angels,' 'All staff were friendly, chatty and professional', and 'We would like to thank the girls…for their kindness, care and friendship.'

Good

Is the service responsive?

Our findings

We received mixed feedback from people using the service regarding involvement in care planning and completion of care plan reviews. However we were mindful that as part of the ethical framework process, the service had taken on a large number of new care packages, along with existing care plans which they were in the process of re-writing and feedback received would have included people who were relatively new to the service. One person told us, "I did a care plan, I think it's in the folder." Another said, "We have a care plan, someone was out to check it a little while ago. If you ring the office they are very helpful." A third stated, "I've got a care plan and they were only out a short while ago to ask me questions and lots of things." Whilst a fourth said to us, "The lady from the office was out yesterday, I had a lot of paperwork to sign, she rang me and asked me questions and then came out." However a fifth person stated, "I've got a care plan but no one has been out in a long time to check, maybe one or two years," Another said, "I can't remember anyone doing a review, someone comes and collects the sheets but they don't ask me anything."

Relatives also described differing experiences, one told us, "We did a care plan at the start and someone comes out to see us and check." Whilst another said, "No-one has been to do a review for quite a while. I know because I would have been there, probably been a year."

The service's customer quality guidance indicated people would receive an initial review after six months, followed by a further six monthly review and full assessment update every twelve months. Telephone monitoring would also be carried out three months after the start of any care package and six monthly thereafter. The registered manager told us during the inspection, they were behind with the completion of reviews due to the ethical framework process and the influx of so many new care packages, however had a plan and schedule in place to ensure these were carried out. In the 16 care files we viewed, we noted both reviews and telephone monitoring had historically been completed consistently, with some deviation in this over the past nine to 12 months, which tied in with the commencement of the ethical framework process.

We looked at how new referrals to the service were assessed. The needs of people were assessed by experienced members of staff before being accepted into the service and pre-admission assessments were completed to ensure the service could meet people's individual needs. This included gathering background information from a variety of sources including other health and social care professionals and from those individuals who were important in people's lives.

Each person who used the service had a care plan in place that was personal to them with copies held at both the person's own home and in the office premises. 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 file was clear and made it easy to access information. We saw care files contained four main sections, the first covered personal information, capacity assessments and information, consent forms and an overview of support required; the second contained the social care support plan which had been completed by the local authority; the third section contained details of people's individual needs and support plans (care plans) and the fourth section contained risk assessments and management plans.

The care plans were comprehensive and person centred. For example the 'individual needs' part of the care file was broken down into ten smaller sections which began with 'my name is…, I prefer to be called….and my preferred method of communication is….' We saw care files contained details about 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. Care files also contained a section titled 'how I make decisions about my day, my care and support', where each person had indicated if they felt able to make the decision, didn't always feel able to make the decisions so offer a limited choice or didn't feel able and preferred others to decide, for each area of their support plan. This ensured staff had the information they needed to provide personalised care which met people's individual needs and wishes.

Each care file we viewed also looked at whether the care provided was meeting expected or required outcomes. For ten specific areas, including health care, personal care, nutrition and hydration, a document was in place which captured what outcomes in that area the person desired, followed by how the service aimed to achieve this, ensuring the person's needs and wishes had been met.

We asked staff how they ensured care provided was person centred. One told us, "I follow the care plan, people's routines and how they want to be supported." A second said, "Each person is an individual, to meet their needs we need to provide care how they prefer it to be done." A third stated, "Every individual is different, I follow the care plan and what it is they want."

The service had a robust complaints policy and procedure in place. The complaints file contained both the policy and guidance for dealing with complaints, which included a flow chart explaining each stage of the process. This ensured all complaints were dealt with fully and consistently. A checklist was also in place, similar to that used in the safeguarding file, to ensure all steps had been followed and evidenced. The file contained a complaints log, which included the name of complainant, nature of complaint, action taken, outcome, date matter closed. For each complaint received we saw a detailed account of action taken had been recorded, with supporting documents attached. We looked at the written responses sent by the registered manager. These detailed the findings of the investigation, what action had been taken and what was being done to address the concerns raised. The letters also contained details of the local government ombudsman, in case the person was not happy with the outcome and wanted to escalate the matter further.

People we spoke with knew how to complain and confirmed that any issues raised had been dealt with promptly and to their satisfaction. One told us, "I only had a complaint two years ago, this was dealt with okay." A second said, "Once they did not give me a bath, my daughter complained and it has not happened since." A third stated, "I did have an issue about timings, they used to come too early to put me to bed, they have now corrected this."

Good

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like the registered provider, 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 service had a clear management structure in place with the registered manager being assisted by a senior care organiser and seven care organisers, who dealt with the day to day management of care packages, calls and enquires. We asked people who used the service if they knew who the manager was and if the service was well run. Due to the set-up of the service and the fact the co-ordinators were responsible for setting up care plans and completing reviews with people, most people we spoke with mentioned the co-ordinator, although some were aware of the manager and their name. One person told us, "I know the girl in the office who does the rota. I know there is a manageress called [name] but I have never met her." A second said, "I know one girl in the office, but I don't know anyone else." A third stated, "I do know the manager's name, but I haven't met or spoken to them." A fourth told us, " The company is very well run, we are very happy with them."

Staff told us they enjoyed working for the company and felt supported. They also felt there was a positive culture within the service, and commented on how flexible they were in accommodating requests and helping out in times of difficulty. One person said, "Best company I have worked for, they look after people." Another said, "It's good. I feel like if I had any issues they would be sorted, They are flexible with rotas and childcare needs as much as possible." A third stated, "They phone me to check everything's okay, always get support if I need it." Whilst a fourth said to us, "What I like is if you report something, they will ring you back to tell you what they have done. This makes you feel valued and your input counts."

Staff told us they felt able to put their views across to the management, and felt they were listened to. One staff member said, "We have staff meetings and area meetings for my working area and we can discuss any problems that have arisen at these meetings. Management are very supportive and always available and I feel I can go to the manager any time I like and will be listened to." Each staff member we spoke with confirmed regular meetings were held ,comments included, "We have patch meetings every couple of months or so and these are useful," and "We have team meetings regularly, we also have a surgery in Marsh Green on Tuesday between 2pm and 3pm, this saves us having to travel all the way here."

The service had a meeting schedule in place which identified meeting dates for the whole year for both office staff meetings, which were held monthly and care staff meetings which occurred quarterly. We looked at records from the most recent monthly staff meetings which were attended by the branch manager, quality monitoring officer, senior care staff and care staff. Discussion topics included: electronic call monitoring; on-call procedure; Outlook; working arrangements; medication; supervisions/appraisals; coordinators surgeries; respect building; growth; care files; customer reviews; communication; quality monitoring; audits and training.

Area meetings were held to discuss issues relating to a particular geographical area in which the organisation provided a service. Discussion topics from the area meetings included: medicines and MAR sheets; reporting concerns; door-step cancellations; recruitment; logging in/out of the electronic scheduling system, staff rotas.

We saw the service completed a range of audits and quality monitoring both internally and at provider level. A quality improvement plan (QIP) was in place which covered all quality issues, concerns, areas of non-compliance; including any actions from local authority audits, inspections, internal audits and quality reviews. The QIP included a red, amber, green,(RAG) rating system to indicate the severity or importance of identified risks or issues.

The service completed a 'self risk assessment' to analyse quality and compliance and identify and issues or challenges along with a 'branch risk assessment and improvement plan' which covered areas such as leadership and management of the service, meeting completion, delivery of service, participation and training completion. We noted an action plan had been drawn up to detail any identified issues or areas for improvement, the plan included the area of non-compliance, who was at risk, level of risk, action required, who by and when. The plan had been signed and dated upon completion.

A provider audit was completed annually which covered all areas of service provision including an overview of the previous audit, complaints, safeguarding, missed visits, medicines management, training, customer contact, documentation and recording. We looked at the last two reports dated 2015 and 2016 and saw the service had received ratings of 98% and 100% compliance respectively. During the inspection we spoke with the providers quality improvement service manager, who told us the next external audit was due to be completed in September 2017. The process would take five days, following which the service would receive an action plan which would be added to the existing QIP. A follow up visit would take place after a further six weeks, to discuss improvements.

In order to support the internal quality monitoring role; the service had two quality monitoring officers (QMO), weekly conference calls were held with all officers within the organisation, where different topics were discussed and information about practice disseminated. The calls were recorded so any QMO's who could not dial in, could access at a later date.

We asked people who used the service if they were asked for their views and opinions either in person or via questionnaires. We received a varied response, with some people telling us they had completed a survey, whilst others stating they had never been asked for their views. We saw the service sent a customer survey to 20% of people who used the service on a bi-monthly basis. The surveys contained a total of 17 questions which covered a range of areas such as, 'does our service help you feel safe and secure', 'do carers arrive on time', 'are you treated with dignity and respect' and 'do carers do things the way you want.' An action plan had been devised to address any concerns raised or for any areas which had been rated as 'sometimes' or 'never'. The registered manager told us the process had been outsourced for the next batch of surveys, in order to speed up the process and ensure actions could be addressed quicker.

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. Staff told us they could access policies by visiting the office and these were also discussed during patch meetings, especially if changes had occurred.

The service had won a number of internal awards, given by the provider. These included Registered Manager of the Year for 2015 and Team of the Year for 2015. We also saw staff were rewarded with vouchers and

certificates to recognise long service.