Ann Mason Care

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Inspection report

Unit 4 Holton Business Park
Holton St Mary
Colchester
CO7 6NN

Tel: 01206233372
Website: www.annmasoncare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 31 October and 2 November 2016 and was announced.

Ann Mason Care is a domiciliary care agency, which provides personal care and support to people in their homes. People receive a range of different support in their own homes, from daily visits, to live-in care. At the time of inspection there were 36 people receiving visits in their home and 8 people had a live-in carer. The service does not provide nursing care.

The provider had appointed a general manager to manager the service on a day-to-day-basis. As a registered person, the provider has legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

This service has been in Special Measures. Services that are in Special Measures are kept under review and inspected again within six months. We expect services to make significant improvements within this timeframe. During this inspection the service demonstrated to us that improvements have been made and is no longer rated as inadequate overall or in any of the key questions. Therefore, this service is now out of Special Measures.

When we inspected in 13 and 14 June 2016 we had a number of concerns relating the lack of oversight by the manager which meant people were not assured of a consistently good service. Following our visit, the manager had worked enthusiastically to drive through improvements and they were able to demonstrate they had a better understanding of the support people received.

There were new systems in place to monitor the quality of the service and a new computer system had been purchased which was intended to address many of the concerns we had raised. A significant number of changes had been introduced over a relatively short period of time. As a result, additional time was needed for these to become fully embedded and for the manager to be able to demonstrate that improvements were sustainable.

People were supported by staff to stay safe in their homes. Improvements had been made to the checks carried out on new staff to ensure recruitment was robust and safe. Staff assisted people to take their medicines as prescribed. Improved checks helped ensure people were receiving the medicines they needed. The manager had revised risk assessments to ensure they were aware of how to support people to remain safe in their homes. There were sufficient staff to meet people's needs and to manage risk safely.

Staff were well supported and spoke highly of the manager. Training had been improved to ensure staff developed the necessary skills meet people's specific needs. The manager had worked with staff to increase their knowledge of the Mental Capacity Act. People were given choices about the care they received. Where people did not have capacity there was an improved understanding of how to make decisions which were in their best interest. People were supported to consume food and drink of their choice. Staff worked well with

health care professionals to help people to maintain good health.

Staff knew people well and developed positive relationships with them and their families. Staff treated people with respect and dignity. Care plans were in place which outlined people's needs and there was in improved system to ensure people's needs were reviewed as required. People received a detailed response when they made a complaint and their concerns were dealt with effectively. The manager had introduced measures to monitor the complaints they received.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The manager had put new measures in place to ensure people were safe, however more time was needed to measure whether the changes were sustainable.

Staff supported people to take their medicines safely

Checks to ensure staff were safely recruited were now in place.

Staff supported people to minimise risk and stay safe.

Is the service effective?

Good

The service was effective.

Training had been improved to enable staff to enhance their skills in meeting people's needs.

People were enabled to make their own choices about the care they received.

Staff supported people to have sufficient to eat and drink and communicated well with other health and social care professionals who were working with people.

Is the service caring?

Good

The service was caring.

Staff knew people well and had developed positive relationships with them.

Staff communicated with people well to understand what their needs were.

Confidentiality was maintained and people were treated with respect and dignity.

Is the service responsive?

Good

The service was responsive.

Support was flexible and responded to individual needs.

People's needs had been recently reviewed and there was a system in place to ensure this happened on a regular basis.

The manager logged complaints and responded to them in a personalised way.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

The manager demonstrated strong leadership and had been pro-active in driving improvements to address concerns following our last inspection.

A significant number of new systems had been introduced and there had not been enough time to ensure they were fully embedded.

There was some dissatisfaction with staff punctuality, however systems to resolve concerns in this area had improved since our last inspection.

Staff felt well supported.

Ann Mason Care

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 31 and 2 November 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to respond to our queries.

The inspection team consisted of two inspectors and one Expert by Experience, who carried out phone calls to people who used the service and their families. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service.

On the day of the inspection we visited the agency's office and spoke with the manager, the business manager and two care coordinators. We also spoke or met with ten care staff. We visited the home of three people who used the service and met with them and their families plus the staff supporting them on that day. We spoke on the phone to eight people and six family members. We also contacted a social care professional to ask them their views regarding the support people received from the service.

We reviewed all the information we had available about the service including notifications sent to us by the manager. Notifications are information about important events which the provider is required to send us by law. We also looked at information sent to us from others, including family members and the local authority.

We looked at five people's care records and five staff records. We examined information relating to the management of the service such as health and safety records, personnel and recruitment records, quality monitoring audits and complaints.

Requires Improvement

Is the service safe?

Our findings

Recruitment processes had been improved since our last inspection and new process were found to be safe. Staff checks included face to face interviews and the taking up of references from a previous employer before staff started working. Any gaps in employment were explored and an explanation given. Office staff carried out disclosure and barring checks (DBS) and disclosure numbers were recorded in personnel files.

When we last inspected the service we had concerns with the checks in place for staff, in particular live-in carers. On our return to the service, we found the manager had been pro-active in resolving our concerns. They had spoken to other care agencies and to the organisation responsible for carrying out checks and had put appropriate measures in place. They had also ensured there was a more robust system in place for checking references were in place before people started working for the agency.

People told us they felt safe with the staff who supported them, "They are all very capable and helpful and they always make me a cup of tea and make sure they leave me with a jug of water. They always check the back door and lock my front door when they go and they make sure I've got my alarm button on." A relative told us, "I do feel [Person] is safe. They read the notes when anyone comes. [Person] comes downstairs and is always smiling. It gives me a chance to have a break and I trust them to do a good job."

Since our last inspection the manager had introduced a new check to measure staff competency in administering medication. They had also improved the medication training staff received. Whilst the changes had improved the support people received when taking their medicines, additional time was required to ensure improvements were sustainable across the whole service.

People told us they were satisfied with the support they received in taking their medicines. A relative told us, "They give [person] medication twice a day. They sign the MAR form and write in the pink folder that they have given the medication. There have never been any problems."

Staff were required to complete medicine administration sheets (MARS) to record when they had supported people to take their medicines. People's individual MAR sheets contained a list of medication which had been written out by staff. It had not been double checked by a second member of staff. This presented a risk as the instructions could be transcribed incorrectly therefore a person could receive the wrong medication. We discussed the risk with a senior member of staff and were advised this would be adjusted in the future to minimise risk to people's safety.

Care plans clearly stated what help people needed, including who was responsible for ordering medicines. A person told us, "Carers helped me sort out the tablets from the GP and they will phone the chemist to find out if they are ready." Where medicines were in a blister pack, they were also listed in the care plan so staff knew what they were administering to people.

However, where staff were administering medicines 'as required' there was not clear guidance in place, which was a particular risk when people were being supported by staff who were less familiar with their

needs. When we spoke to staff during our visits to people's houses we found they knew what to do, despite there not being written guidance in this area. We were told by the manager that they would amend the care plans to ensure all staff had more adequate advice about required medicines.

Where people were independent with taking their medicines, we received feedback that staff monitored and gave them reminders. One person told us, "They don't give me my tablets but they will check. They laugh and say 'I see you've taken your tablets'." A relative said, "They don't do the tablets. I do that. But they might just check and remind me to give [person] their tablets."

Staff had attended training in safeguarding and were able to confirm that they would report any concerns immediately to protect people. Staff were able to give us examples of abuse which they would look out for. For example, a member of staff told us they looked for, "Anything out of the norm and which I'm not comfortable with. If the client is reacting differently to you. Even things like how quickly they consume food."

We saw an example where the anonymity of a whistle-blower had been maintained when they had raised concerns regarding the support a person was receiving. We were shown a number of examples where the manager had raised safeguards with the local authority when they were concerned about a person's safety.

Detailed risk assessments were carried out and comprehensive plans were in place for each area where people were found to be at risk. For example, one person was found to be at risk as they were not able to communicate verbally and there was guidance in place for staff to enable them to minimise this risk. Where necessary, there were measures in place to minimise injury to people. For instance, initial assessments established whether a person was at risk of pressure sores and if so, there were details about the involvement from district nurse.

Where people were felt to require urgent assistance we saw examples on care records where staff had responded appropriately. A person described how, "I have been unwell when they have visited me and they have phoned for the GP and for the paramedics and they always wait with me."

Where equipment was used, support plans detailed the exact support needed and where outside professionals were involved. A relative told us staff had the skills and confidence to keep people safe when using equipment. They said, "They use the hoist to lift [person] into their chair. Staff all seem very confident in how to use the hoist."

Since the last inspection the forms had been revised to ensure information was easily accessible to staff and review dates were clear. We found the risk assessments to be of a good quality and to provide vital information to staff.

There were plans in place to support those people most at risk in the event of an emergency, such as flooding. Office staff had put robust measures in which would support the service if their computer system failed. This ensured there would be information available for staff to continue providing flexible and safe support, even if there was a power failure at the office.

Staff said they always have two staff available for when required. Staff said they had enough time to carry out care visits but if they needed more time they would tell the office and felt they would be listened to. Staff told us where possible they saw the same people. One member of staff told us, "Over a two week period I will generally see the same clients so you know your clients and can pick up a problem. It's constant monitoring."

The feedback we received confirmed the service aimed for continuity when allocating staff rotas. Most people stated that although they had different staff, they were supported by a group of staff with whom they had familiarity. For example, one relative told us, "We have fairly regular carers looking after [person] - about four or five rotate which helps with continuity. [Person] has dementia and the other week I had a phone call, as they hadn't recognised the carer. The office had to send someone else as they were short of staff. The carer phoned me and I spoke to [person] and reassured them and it was fine. I'm glad the carer phoned me."

There was a clear system to coordinate breaks for live-in carers, which helped ensure they were not too tired or isolated to carry out their work safely. Where a person was assessed as not being able to be left safely for two hours we saw that cover was arranged, and visited a person during the handover between the live-in carer and the substitute staff.

People gave particularly positive feedback about staff's attention to cleanliness around the house and when providing support. We were told by people that staff always carried gloves and other protective equipment and would wear these when required. People told us, "I have noticed that they are good at washing their hands" and "They always wash their hands and wear gloves. I'm fussy about that sort of thing."

Good

Is the service effective?

Our findings

During our last inspection we had concerns about the induction and training provided to staff. Since the inspection, the manager had made a number of improvements to the training staff received. They had employed a new member of staff to carry out more practical training to complement the existing computer based learning. They had also purchased a bed and a hoist, which could be used to provide more practical manual handling training to staff. The manager told us that due to the concerns found in the inspection they were providing training for all staff to refresh their knowledge. They showed us a chart which tracked what training staff had received and if there were gaps, we saw there were planned dates for staff to complete training.

When we last visited, we had some concerns regarding the training provided to live in care staff who came from abroad. The manager told us the service provided accommodation in a local house when staff first arrived in the country. New staff lived there briefly before moving in to people's houses. This gave the manager the opportunity to carry out an induction and to provide a handover to new staff. In the past, it had been difficult for the manager to check and evidence whether staff had the necessary skills. This concern had been resolved by the improved systems in place.

A new computer programme had been purchased to enable the manager to better match staff to the people they supported. For example, if a member of staff had been assessed as needing more training in using a hoist the system would put a block on the scheduling of rotas to ensure that member of staff was not sent to support a person who used a hoist.

The new system was due to be introduced shortly after our inspection. However, we found that the manager knew people and staff very well and through our observations and discussions, we were assured that there was a careful approach to matching was already in place. For instance, where a live-in carer was unexpectedly absent on the day of our inspection the manager took time and effort to ensure the person knew the member of staff member who came in to cover at such short notice.

Training was flexible depending on the needs of the people staff were supporting and on existing staff skills. Therefore if a member of staff was providing live-in care to a person the manager made sure they had the necessary training and skills to meet their specific needs. We visited a person being supported by a live-in carer and spoke to their main member of staff and the staff who covered for them when they took a break. They were able to describe in detail the person's specific needs and how they managed them.

We received positive feedback regarding staff skills. One of the people we visited said, "They are excellent these girls, they've got it all down to a very fine art." People were cared for by staff who told us they felt well trained. Staff said they received good induction training when they started working at the service, which helped them to know and effectively meet the needs of the people they provided care too. Induction also included a period of shadowing more experienced staff until they felt able to make the care calls on their own and deemed competent. A member of staff told us, "After I'd shadowed then somebody else shadowed me to check I felt confident."

Whilst there was a recommended time for each new member of staff to shadow we were shown an example where a new staff member had been required to shadow for considerably longer until the manager was sure they had the necessary skills. A relative told us, "There have been a couple of instances where there have been two carers come out and that's when there is a new carer who is being shown what to do."

During this inspection we had noted that staff had the skills to work with people with dementia. A relatively new member of staff explained how they were supported to develop these skills during their shadowing. They told us, "When I was shadowing the other carer gave me a brief before we went into the client with dementia and what to expect. The carer was very calm and advised." We noted staff worked well with the Alzheimer's Society and so had received guidance regarding best practice in this area.

Spot checks and competency assessments were carried out and until these were signed off staff had to be supervised on visits. Competency assessments included sitting to standing, manual hoist, ceiling hoist, catheter care, fluid and nutrition, administering medication. A record of the checks was kept in staff files so the manager could monitor any gaps in knowledge and skill.

At our last inspection we had concerns regarding the consistency of staff supervision. Supervision of staff was now more structured and the manager could demonstrate all staff were being monitored effectively. Individual meetings with staff were used to improve the service people received. For instance, supervision with one member of staff was arranged to discuss a complaint about their attitude. A senior member of staff told us they worked alongside the member of staff until they were assured there had been an improvement. Where staff were disciplined, communication was sensitively worded, yet clear firm, demonstrating the manager prioritised improving the quality of their staff team.

Staff said they received support and supervision on a regular basis and records confirmed this. "I have formal supervision every eight weeks but there is always an opportunity to come and talk to [manager] at any time" and "You are always made to feel welcome at the office there is always someone to talk to and to ask for advice or just to have a chat." There was a good understanding of staff needs and their right to privacy, so any personal discussions with the manager were not shared with other office staff.

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. At our previous inspection we had concerns regarding how the legislation was being adhered to at the service. At this inspection staff spoken with were able to talk about the MCA and how they put this in to practice. They had all been required to do refresher training in this area since the last inspection.

The manager and a senior carer were attending an external course looking at MCA and DOLS which would enable them to improve their knowledge of the laws in this area. In our discussions, we found the manager already had a good understanding about what to do when a person lacked capacity. They ensured staff had the skills to encourage and prompt people who refused care to ensure people were supported sensitively to receive care that was in their best interest.

Care plans had been revised to provide advice to staff where people lacked capacity to make decisions about their care. We saw guidance in place where a person had a Lasting Power of Attorney. Where other

people lacked capacity we saw records of discussions with their families and other professionals when decisions were made about their care. In particular, we found guidance was of a good quality for staff supporting people who lacked capacity due to difficulties with memory.

Staff supported people to have enough to eat and drink. We observed staff preparing a meal at a person's house and confirmed it was the person's choice what they ate each day. Another person told us, "They make my evening meal and always give me a choice. I usually have a sandwich or something like eggs on toast."

There were plans in place where a risk assessment indicated that a person might forget to eat due to difficulties with their memory. There was detailed information to staff to enable them to fully understand how the person's dementia put them at risk. Guidance was practical. For example, staff were told a person might say they had eaten when they had not and to place food in front of them and prompt them to eat. There were then food charts and detailed daily records to help monitor what the person was eating.

Relatives confirmed staff had the skills to support people with complex needs to maintain nutrition and continue to be involved in making choices, "They don't just go in and rush out – they sit with [Person] and encourage them to eat their food. I think they understand about dementia, for example they give a choice at meals but only offer two choices so that [Person] isn't overwhelmed but still has some choice. If they say they don't want to eat staff gently encourage or they say that I have told them to make sure [Person] eats it and that often works."

Where people had complex needs, these were detailed in their support plan. For instance, a person's plan referred to guidance from a Speech and Language Therapist that they should not drink with a straw as this was a risk.

People's care plans included detailed information outlining specific health conditions. For instance, we visited a person who needed to use equipment to have oxygen at home and there was detailed guidance in place for staff. Staff skills in relation to specific conditions was promoted and valued. For instance, a member of staff told us they had been on a course about Motor Neurone Disease and had cared for three people with this condition.

We received positive feedback about support received from the manager, who had a nursing background as people and their relatives told us they felt this had helped manage complex health conditions. They also felt well supported in their contact with other health professionals. One relative told us, "The care plan was recently updated and it's through the carer that we have now got the continence service involved as [Person's] continence needs have increased. The carers check [Person] for pressure areas and recently flagged up a pressure sore." We saw on the person's notes that staff had contacted a district nurse to request a review with the continence team and to ask for an assessment for a pressure cushion.

When we visited a person in their home, we saw that staff were in touch with their occupational therapist (OT) to help resolve issues with some of their equipment. A relative of another person told us, "We've got rotundas, glide sheets and a commode. All the equipment was started off by the manager getting in touch with the OTs regarding equipment needed. All the carers are trained by the OT in how to use the equipment. It's much easier for us now that the manager has got them involved."

Staff helped monitor people's on-going health and supported them to speak to their GP when there were concerns. One person told us staff had encouraged them to get their GP to look into a specific condition. Another person told us, "The agency work with my GP surgery too and will liaise with them on my behalf."

Good

Is the service caring?

Our findings

We received positive feedback from people about how caring staff were. One person said, "Each and every one of the carers makes you feel like you're special. They very much listen to me." Another person told us support had been arranged to help reduce their loneliness. They said, "We sit and have a coffee. They are so friendly and can't do enough for me. They have become friends."

Relatives also told us staff were kind and gave us examples of the positive relationship they had with people, often saying how 'fun' staff were. For instance, relatives told us, "I'm full of praise for the care. They are bright and cheerful and he is always smiling when they are here. They have a laugh with [Person]. We all like one another. They will do extra little jobs and we never feel rushed" and "They communicate so well with [Person]. The carers cheer her up and even get her singing. They encourage and chat with [Person]. Some days she'll see them and her face lights up."

When staff spoke to us about people they knew them well and spoke warmly about the support they provided. A relative confirmed staff knew their family member well, "I can't fault them. They chat to [person] and they know their interests." We observed staff supporting people and saw that they were friendly yet respectful. Staff told people what they would be doing during their visit. We noted staff informed people of each task they were going to carry out.

We had particularly positive feedback about how the skills staff had to support people with dementia enabled people to feel special. One relative told us, "They go the extra mile. The girls are all lovely and cheerful. They all have a nice way with [Person]. They kiss her hello, are very respectful and she loves them. I know sometimes people with dementia can be quite depressed too but she never is and I think that's partly because of the carers. [Person] loves them." Another relative told us, "I do feel that they know about dementia. For example, there are photos of the family around the room and they will talk to [Person] about them and will mention relatives who died many years ago as the carers know they like to talk about the past."

Staff communicated with people to ensure they made choices about the support they received. A member of staff told us, "I am led by the clients - their wishes, their life. You do what they want in their home." A person told us, "They always check with me and my wife saying 'Is that alright,' or 'is it ok for us to do this'?" Where people lacked capacity to make a full decision, staff had the skills to involve people where possible. For instance, staff were told rather than asking what a person wanted to wear, they should offer them the choice of outfits. As a result the person was involved in making choices, whilst still receiving the appropriate level of support.

The compassionate nature of staff was appreciated by family members who told us they felt supported in their caring role. One relative said, "I feel that the carers are very good. They listen to me and support me which is very important at the moment." Another relative told us staff communicated well with them which ensured the support run smoothly. They told us, "I leave a book out for communication between me and the carers and they always write in it as well as in the folder. They will write what [Person] has had to eat and

drink. If I speak to a senior carer about anything I know they will let the carers know what's needed, often by email."

People's dignity and privacy was maintained by staff. A relative told us, "I can't praise [staff member] enough. They are very sensitive to my family member's needs and are always very professional." One member of staff told us about a particular person and how important privacy was when personal care was being carried out. The staff member described in detail how they ensured their dignity was maintained and demonstrated a high level of compassion and respect. Another member of staff told us, "A lot of the clients have key safes and I always make sure that I knock before entering. I make sure that curtains are closed and doors closed and cover with a towel when doing personal care. I'll always ask. The best people to tell you what they want are the clients."

Staff told us staff preserved their anonymity and never shared confidential information. One person told us, "They never talk about any other clients they have. They might say 'I'm going to this area next and we work out the best way to get there but they never mention names." Another person said, "There are three of us [in this area] who have Ann mason care but the carers never talk about the other people to me." A member of staff told us how important confidentiality was. They said, "We must never talk about people as you stand outside their home. You never know whether the neighbours can hear."

Good

Is the service responsive?

Our findings

At our previous inspection, we found care plans did not have the necessary information to meet people's needs. There was not an effective system to ensure care plans were reviewed regularly and consistently. The provider did not log or audit the complaints they received.

At this inspection, the manager was able to demonstrate where improvements had been made and provide additional information to address our concerns.

People received personalised and flexible support. Feedback from one person reflected the positive feedback, "I'm very satisfied. They will do extra jobs such as put the washing machine on or make my bed. It's always nice to see them. For example, I was airing some clothes this morning and the carer asked if I wanted it folded. They always check with me before doing anything."

The majority of feedback we received about staff timekeeping indicated people's needs were met even if visits were not at the exact time each day. Where visits were flexible this was in line with people's expectations. For example, one relative told us, "The timings can vary. There are not specific times that they come. It's usually within a 2 hour slot. At the latest the morning visit is about 9.45am but [person] likes a lie in so it's not a problem. They always stay for the full time." Staff told us if they were going to be late, they would ring the office who would let the person know.

There was a system which staff used to 'clock-in and out' so it was straightforward for the manager to check the staff punctuality and the length of time they stayed at a person's home. We looked at the timings of visits and could see staff usually arrived at the times which as had been set up in their care plan and stayed for the agreed length. This system also flagged up any missed visits, though we had very little feedback that missed visits were a problem. A person told us, "They have never missed a call and do phone me if someone is off sick to let me know."

During our inspection, the manager highlighted that they had become aware of a particular geographical area where visits had not been co-ordinated as well as the rest of the service. We noted that all the negative feedback about punctuality came from this area. The manager described how they had pro-actively resolved the issue and improved how staff working in that location were co-ordinated. We found this had been dealt with positively and in a manner which aimed to address much of the negative feedback we had received.

Care plans had been revised and were personalised to reflect people's needs and preferences. For instance, one person's plan said, "[Person] likes crunchy nut cornflakes and a cup of tea without milk." We checked plans during our visits to people's houses and saw these corresponded to the plans held in the office. I spoke to staff about specific people they supported and they were able to confidently tell us about their health and other needs and talk about their history and interests.

Plans provided good advice to staff about what to do it a person refused care. For instance, one plan said

that if a person refused a bath than it had been agreed a body wash was acceptable. We spoke to the person and they told us, "Carers always check that I am OK before they do anything. They will ask 'Do you want a shower today or shall I just help you with a wash?'"

People had their support reviewed every six months or if their needs changed. A person told us, ""They have rewritten the care plan recently as we have increased the care and number of visits." We saw in a person's notes that their daughter had been invited to a review as they were very involved in their care. In response to the feedback received at our last inspection the manager now had a system in place to monitor the frequency of people's views and to ensure there were no gaps in the programme of reviews.

People told us they had received a good response when they had asked for a change in their support. A person told us, "They are flexible for example if I want to go to the club they will make sure they send somebody early to help me get ready."

In particular, people with live-in carers were enabled to live full lives with flexible personalised support. We visited a person who had a live in carer. They were able to go out on trips, for example for religious events, as they wished, as staff were always available to meet their personal care needs when they were out.

Since our last inspection, the manager had set up a log of complaints so they could log people's feedback. None of the people or family members we spoke to had made an official complaint but they told us they felt able to speak to the office or a senior member of staff. Two relatives gave an example of where they had contacted a senior carer to give feedback about a member of staff. They told us they were satisfied with the response they received as their concerns were resolved immediately. We saw an example where a person's feedback had been recorded as a complaint to ensure it was dealt with effectively. People received a personalised response to their complaints.

The manager told us they had used surveys in the past to gain people and their family's views and were planning to introduce improved surveys. They demonstrated a high level of enthusiasm to receive feedback about the service being provided.

Requires Improvement

Is the service well-led?

Our findings

In our discussions with the manager it was clear they had put a great deal of effort into resolving the concerns raised in our last inspection. We also received feedback from the local authority that the manager had worked positively with their officers to introduce new processes.

Many systems which had been already been in place previously were now more structured and robust. For example, the managers now met formally to discuss the key aspects of the service, including any complaints which had been received and any risks. As a result the manager had an improved oversight of what was happening at the service and they could be assured people were getting the support they needed.

The manager told us they were pleased with the way the service had developed since our last inspection. However, whilst the changes were positive, there had not been enough time for them to become fully embedded and for us to measure whether improvements were fully sustainable. Some changes were ambitious, for example the manager told us they were planning to have team meetings fortnightly, and more time was needed to see whether this was practical over a longer period of time.

At our last inspection, a number of our concerns centred on the checks and supervisions of the live-in carers. The manager had shown strong leadership by personally taking over managing this part of the service. They had ensured they had increased oversight of the quality and thoroughness of the checks on all new staff, including the live-in carers.

The manager showed us a new database which had been purchased to support them in managing the service. During our visit we were told the system had not yet gone 'live' as they were still testing it but we were shown its potential by the business manager and a care coordinator. They were passionate about the new programme, and were able to demonstrate how people's support would be improved as a result. For instance, there would be much better information available about people's needs and staff availability, if emergency cover was needed at short notice. The business manager told us in the past they had introduced change too soon and they had learnt from their experience and so were carrying out the necessary tests before introducing the new programme.

The manager had also purchased an improved system to ensure their audits were enhanced. There were improved checks on the quality of the care plans and the manager had a better system to monitor when reviews of people's needs were due. Effective systems were in place to ensure other records were checked, such as the daily notes completed by care staff. The manager had personally carried out quality checks since the last inspection and was slowly training other senior staff to share the role of monitoring in the future. The manager told us they had trialled the new auditing system by checking staff files and had picked up that a member of staff had not received supervision as required.

Whilst people were generally positive about the service, there was some dissatisfaction with the staff punctuality. We had checked records of staff visits as these were available electronically and found the times to be predominantly in line with people's care plans. There appeared to be pockets of dissatisfaction in

particular locations. The recent improvements in reviewing people's care would now provide an opportunity for them to discuss any concerns with a member of staff. In addition, the improved systems for checking the quality of the service would enable the manager to be more aware of any specific issues around staff punctuality.

People told us they appreciated being supported by a family run organisation, in particular the access this gave to the manager of the organisation. A relative told us, "It's a family business. The manager has given me their mobile number for use in an emergency and we are very satisfied with all the help they give us." They told us they appreciated the personal response they received. A person told us, "I have phoned the office occasionally and there is a polite young man who answers and passes on messages." People told us the service was an important resource in a largely rural community. One person told us, "Getting carers in this area is like hens teeth. I have recommended them to other people and can't praise them enough."

Staff spoke respectfully about the manager and said they were very supportive. Staff told us, "If there is ever a problem it's dealt with. I have phoned the manager several times at 7am and they are always there and provide answers to my questions" and "[Manager] is so supportive, the best manager I have ever had."

Staff also said morale was good in the organisation. We spoke to or met ten staff and only one or two staff gave any negative feedback. One member of staff told us, "You are in contact with other carers through the double up visits and they seem happy," and another said, "We work as a team and support each other." Staff told us the office staff and caring staff communicated well. A member of staff told us, "If you have a problem the agency always backs you up. I always feel able to ring the office- there is always back up."

The manager demonstrated that they spotted potential from within the staff group and offered opportunities for progression. We saw that a talented member of staff had been supported to attend additional training courses.

The manager and other staff demonstrated an enthusiasm to introduce best practice, and engaged positively with outside organisations to ensure they had access to good quality information and resources. For instance, the manager had acknowledged their former policies and procedures had not suited the service being provided. They had researched different options and had purchased an improved set which were more practical and easy to understand. Whilst many of the changes were in their infancy the manager demonstrated a commitment to driving improvement which assured us the quality of support people received would continue to improve.