Everlasting Care Ltd

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Inspection report

102 Howard Street
North Shields
Tyne And Wear
NE30 1NA

Tel: 01912574575
Website: www.everlastingcare.co.uk

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Everlasting Care Ltd is based in North Shields and provides a domiciliary (care at home) service for approximately 70 people most of whom are elderly or have physical and/or mental health related conditions living throughout North Tyneside.

We last inspected the service in December 2014 and rated the service as 'Good.' At this inspection we found the service required improvement. This was because they were not meeting some legal requirements.

A registered manager was in post and this manager had not changed since our last inspection of the service. The registered manager was also the provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The registered manager was on annual leave at the time of our visit to the office. On her return, we spoke with her about the service and our findings. She shared further documentation for us to review which had not been accessible to the office staff at the time of inspection.

A robust induction programme such as the 'care certificate' had not been fully implemented at the service and because of this some staff had not had their competency assessed against the minimum standards which are expected. Formal 'on-the-job' competency checks of experienced staff were not always conducted. Training had not always been routinely refreshed and specific training to meet the needs of the people who used the service such as dementia awareness and challenging behaviour was not routinely arranged.

Risk assessments had not always been carried out to address the individual risks people faced in their daily lives. Those which were in place did not consistently contain plans for managing or reducing risks and required some further development. We have made a recommendation about this.

Some checks were carried out to monitor the quality and safety of the service. Although there was no evidence of auditing or analysis of the overall service, the oversight of service delivery through spot checking of care staff and the records kept in people's own homes had been effective to a degree and highlighted some areas for improvement which were promptly addressed by the office staff. The issues we found regarding the lack of individual support plans, risk assessments and training had been partially identified prior to our inspection but were not fully addressed. We have made a recommendation about this.

Recruitment checks were carried out to ensure that staff were suitable to work with vulnerable people and there were sufficient numbers of staff employed by the service to meet people's needs and preferences. We saw evidence of a shadowing period for new staff. All staff were supported though an annual appraisal however formal periodic supervision sessions were not carried out.

There were safeguarding procedures in place. Staff were knowledgeable about what action they should take if suspected anyone was at risk from harm or abuse. The local authority safeguarding team informed us that were no on-going organisational safeguarding matters regarding the service.

Medicines continued to be managed safely and administration procedures were followed correctly by care workers. People's nutrition and hydration needs were met and they were supported to access healthcare services when required to monitor health and well-being.

People's rights under the Mental Capacity Act 2005 (MCA) were protected. Care staff supported people to have maximum choice and control of their lives in the least restrictive way possible; company policies and procedures supported this practice. Care records showed people were involved in their care and support.

We observed lots of positive interactions between staff and people who used the service. Staff demonstrated a caring and compassionate attitude and they protected and promoted people's privacy and dignity.

All staff were very positive about working for the company, which they described as 'family run'. They all told us they felt valued and enjoyed their roles. We observed that they projected this positivity when they engaged with people.

Person-centred care plans devised by the service were not always in place. Those which were detailed the individual care and support people required. Information from other agencies such as the local authority was available to staff. Reviews of people's needs required further development. We have made a recommendation about this.

Care staff demonstrated that they knew people's likes, dislikes, preferences and routines. Arrangements for social and emotional support met people's individual needs.

There was a complaints procedure in place. We reviewed the complaints received by the service since our last inspection and saw they continued to be responded to thoroughly and in a timely manner.

We have identified one breach of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 entitled Staffing. You can see what action we told the provider to take at the back of the full version of the report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Individual risk assessments were not always in place to meet specific risks people faced in their everyday lives.

Emergency procedures were not documented in the records kept in people's homes. Accidents and incidents were recorded but action was not always taken to review or update risk assessments following an event.

Safeguarding procedures were followed correctly and medicines continued to be managed safely.

The recruitment of staff was safely undertaken and there were enough staff employed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

A robust induction process had not been implemented at the service. Training in key topics had not been completed by all staff and training to meet individual people's needs had not been routinely undertaken by the care workers who supported them.

Formal competency checks had not always been carried out, neither had periodic one to one supervision sessions. Annual appraisals had taken place.

Staff understood the Mental Capacity Act and worked within its principals.

Staff supported people to meet their nutrition and hydration needs and there was ample access to external professionals to monitor health and well-being.

Is the service caring?

Good

The service was caring.

People and relatives spoke extremely highly of the care workers

and the office staff.

All staff demonstrated a kind, caring and compassionate attitude and they treated people with dignity and respect.

People and relatives had been involved with the care planning process and given consent to the support they received.

Care workers promoted people's independence and displayed patience and understanding.

Is the service responsive?

Requires Improvement

The service was not always responsive.

Person-centred care plans were not always in place. They did not always contain up to date information and a review of people's needs was not thorough enough to ensure people received the most appropriate care.

Care workers provided social support and ensured people were not socially isolated.

Two external professionals gave us good examples of when the staff had acted in a responsive manner.

Complaints continued to be managed and responded to in a timely manner.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Records were not always comprehensive and in place to demonstrate compliance with the regulations.

Audits and checks on the service were not robust enough to fully identify and address the issues we highlighted. There was no analysis of the overall service carried out.

The management team were well liked by care staff who told us they felt valued and confident to approach the management about any concerns they may have.

There was an open and transparent culture at the service and the management demonstrated their willingness to improve the service.

Everlasting Care Ltd

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 25 and 27 April 2017 and was announced. We gave the staff 48 hours' notice because the location provides a domiciliary care service and we needed to ensure there would be staff available at the provider's office to access the records. The registered manager was on annual leave. Following her return to work we carried out further inspection of documents shared with us on 17 May 2017. The inspection was conducted by one adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience made telephone calls to people and relatives between 25 and 27 April 2017.

Prior to the inspection we reviewed all of the information we held about Everlasting Care Ltd, including whether any statutory notifications had been sent to us by the provider and any safeguarding information we had received. Notifications are made to us by providers in line with their obligations under the Care Quality Commission (Registration) Regulations 2009. These are records of incidents that have occurred within the service or other matters that the provider is legally obliged to inform us of.

As part of the inspection and by prior arrangement, we shadowed two care workers as they carried out their duties on the afternoon of 25 April 2017. We spoke with three people and two relatives during this time. We also contacted 11 people who used the service by telephone to gather their opinions and we spoke with three relatives to acquire their feedback. We spoke with five members of staff, including two deputy managers, a supervisor and two care workers. We contacted 14 members of staff by email, of which seven responded to our questions with comprehensive feedback. We reviewed a range of care records and the records kept regarding the quality and safety of the service. This included looking at seven people's care records and three staff files.

Additionally, we contacted North Tyneside local authority commissioning team, adult safeguarding team

and care management teams to obtain their feedback about the service. On this occasion, we asked for a Provider Information Return (PIR) prior to the inspection. The PIR is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. All of this information informed our planning of the inspection.

Requires Improvement

Is the service safe?

Our findings

Basic risk assessments were drafted to support staff with their duty to care for people safely, however they concentrated on general needs and environmental factors. We found that risk assessments were not person specific as they did not always address the individual needs which people faced in their everyday lives. Generic risks to aspects of people's health, wellbeing and daily living such as medicine, mobility and their home environment were repeatedly recorded in the records we reviewed. Risk assessment documentation detailed some possible hazards but did not include strategies for staff to prevent incidents and actions for them to take in the event of an incident. When we spoke to staff they were aware of the individual risks people faced and the lack of documentation had not impacted on people receiving care safely. We discussed this with the office staff who told us they would ensure a thorough individual risk assessment was completed for each person to ensure current guidelines and best practices were followed.

We recommended the service sought advice and guidance from a reputable source regarding individual risk assessment documentation.

People's individual care records did not include information for care workers around what action to take in the event of an emergency in people's homes, such as a fire, flood, gas leak or power cut. The office staff told us they would include this information when they redrafted the risk assessments. The registered manager later sent us evidence which showed that risk assessments had been developed to include this missing information in future. Care workers we spoke with were able to describe their responsibilities in the event of an emergency and told us they would contact the office to report it.

Accidents and incidents within the service had mainly involved the staff. We saw an accident book was used to record this information; however there was no documented supporting evidence of investigations, changes or control measures put into place to avoid a similar occurrence. For example, an environmental risk assessment did not appear to have been reviewed or updated following an accident involving a care worker at a person's property. The office staff told us they could not recall any incidents involving people who used the service which would be notifiable to the Care Quality Commission (CQC).

The office staff managed an 'on-call' service which operated outside of normal office opening hours. They were available to support staff and for people to contact in an urgent situation. Information was verbally passed from 'on-call' officers to the office staff each morning however no daily written records were kept of incoming and outgoing calls during this time to ensure that issues and concerns which were reported were actioned by relevant staff or external agencies as necessary. The office staff told us they would create a daily 'handover' log for future use. 'On-call' staff had secure access to the contact details of people who used the service and their relatives, in case of an emergency. Staff contact details were also accessible so they could be called upon 'out of hours' if needed in an emergency situation, such as unplanned staff absence.

We asked people who used the service if they felt safe with support from their care workers. Comments received included, "The staff are very good to me and I feel very safe with them", "They look after me very well", "There has never been one unpleasant moment with them" and "I feel safe in the shower with them

[present]." The relatives we spoke with echoed these comments. One relative told us, "My wife feels very safe with them while she is in the shower; they are very good with her."

Safeguarding policies and procedures were in place in order to protect people from harm or improper treatment. Incidents of a safeguarding nature within the service had been appropriately recorded and responded to. The registered manager had referred these onto the local authority as necessary. Most staff had completed a safeguarding of vulnerable adults training course and those we spoke with were able to describe their responsibilities to report safeguarding matters. Care workers told us they were not concerned about anybody in their care, they demonstrated a thorough understanding of the policies and procedures in place and they told us they would have no hesitation to report any issues to the office staff. The office staff were able to describe their responsibilities with regards to referring certain incidents onto external agencies such as the local authority, CQC or the Police.

There was an up to date 'critical incident' policy in place which contained information to support the staff and ensure the service could still operate in the event of a crisis, such as flooding or IT failure with minimum disruption. Other aspects of the service such as staff shortages and extreme weather conditions were appropriately planned for with arrangements and alternative plans documented.

People, relatives and staff told us they felt there were enough staff employed by the service to meet people's needs. People and relatives described a reliable and consistent service. Comments included, "They are normally spot on time, if they are going to be late they let me know, and it's usually due to the last appointment needing extra help", "They are very good, I always get the same carers", "Time keeping is pretty good, they can be a little bit late but only by a few minutes", "We have a set routine now which works well, they managed to fit in the hours to suit us" and "We have two regular carers, who always arrive together and normally on time. We reviewed the staff rotas for the previous four weeks and saw care workers were allocated to regular 'runs' with the same people to visit each day or week. Care workers told us they had gaps in their rotas to have breaks and had enough travelling time. The care workers we spoke with confirmed they were not hurried in their duties and had plenty of time allocated to support people.

The registered manager continued to ensure the staff they employed were suitable to work with vulnerable people. We examined three records of staff who had been recently recruited. Staff files contained evidence of an application for employment, interview and pre-employment vetting checks. With the absence of the registered manager, the office staff did not have access to some of the checks we required sight of. This information was later provided by the registered manager on her return to work. The office staff told us they would benefit from a recruitment checklist, so they could see at a glance what checks had been applied for and what had been received. They told us they would develop this area of the recruitment process. This demonstrated that the registered manager safely recruited staff with a variety of skills and experience and checked that they were of suitable character to meet the needs of the people who used the service. The staff we spoke with confirmed these checks had been completed prior to their employment.

The office staff carried out 'return to work' interviews with staff following periods of sickness and there was a disciplinary policy in place for when staff fell short of company expectations. This showed that the registered manager continued to ensure all staff remained suitable to work with vulnerable people.

We checked how well the service managed people's medicine needs. People told us their care workers "never forgot to give them their medicine", and "always made sure they took them". The office staff told us, "Care workers are mostly [verbally] prompting people to take their medicines." All staff had completed a safe handling of medicines awareness course and there was a strict policy in place for the staff to follow with regards to the ordering, receipt, storage, administration and disposal of any medicines. The service

preferred people's medicines to be stored safely in 'dosette boxes' filled by a pharmacist. This meant people could access their own medicine independently without fear of getting their tablets mixed up. Care workers signed a Medicine Administration Record (MAR) to show when support had been given which included, verbal prompting and administration. We reviewed some MAR's and saw they were legible, well maintained and up to date.

Separate medicine risk assessments were in place for some people but they were not present in all of the records we reviewed. Those available mostly contained generic risks around medicine support. Specific risks, such as why a person's medicines were locked in a safe or the administration of medicines with special instructions were not explained, however a care worker told us, "Special instructions are usually highlighted on the MAR." We asked the office staff to consider some individual examples when redrafting risk assessments. The care workers we spoke with were aware of people's individual risks and supported people appropriately. We noted there had been no issues related to the management of medicines and no concerns or errors had been reported.

Staff were provided with uniforms and personal protective equipment (PPE) such as disposable gloves and aprons to protect themselves and others from cross contamination when working in different people's homes. People told us their care workers had high regard for infection control and always had a supply of PPE readily available which they disposed of responsibly. We observed staff using PPE and changing it between tasks such as continence assistance and medicine administration. A relative told us, "They are always clean and tidy, in their uniforms, they demonstrate good hygiene practices."

Requires Improvement

Is the service effective?

Our findings

The registered manager used a training matrix and report to record the dates of when staff induction and training was completed so they could monitor when refresher training was appropriate. Neither however specified when people were employed so it was difficult to ascertain if training had been delivered in a timely manner.

The registered manager expected staff to complete training in topics which they deemed mandatory such as safeguarding vulnerable people, moving and handling of people, medicine awareness, health and safety, food hygiene and infection control. This was conducted through an in-house induction, training sessions and external courses. However we found there were a lot of gaps in the training matrix where existing staff not had yet completed a course or had not had their knowledge refreshed. For example, the training matrix showed several staff had completed safeguarding training. Training in dementia awareness had not been completed by the majority of staff and care workers supporting people with health conditions such as epilepsy or diabetes had not received any training relevant to these needs. The training report showed that only two supervisors had completed a challenging behaviour course despite care workers working with people whose behaviour may challenge them on a daily basis.

Some staff had been given an opportunity to enrol in qualifications in Health and Social care at levels dependent on their role to enhance their personal development. All members of the management team were working towards or had achieved nationally recognised qualifications at a higher level, but not all care staff had been enrolled or completed the qualification. Some of which had been employed more than one year.

We saw in the three staff records we examined that staff had undergone an induction into the company which covered the policies, procedures and operational activity of the service. It also included shadowing of experienced staff. There was no evidence that a robust common induction package such as the 'Care Certificate' had been completed by these three staff in the first 12 weeks of their employment. After the inspection the registered manager told us that all staff (without previous care experience) were supposed to complete an induction similar to the 'Care Certificate' induction process. The Care Certificate is a benchmark for the induction of staff. It assesses the fundamental skills, knowledge and behaviours that are required by people to provide safe, effective, compassionate care. We considered the induction process in place was not sufficient. The information we reviewed demonstrated that there were gaps in the system which had been set up to ensure staff had the skills and competence to carry out their role before they were allowed to work unsupervised. The three staff whose files we examined had not undertaken a robust induction as they should have done but had completed an assessment of learning with an in-house training officer during their induction period. However these care workers' had not had their knowledge followed up with a formally assessed competency check as they would have done with the 'Care Certificate'.

A probationary period was in place for new staff and this was monitored and reviewed at regular intervals by the office staff. Following a successful probationary period staff received an annual appraisal. Regular formal one-to-one supervision sessions were not in place throughout the year which meant staff did not

have a formal opportunity to discuss their progress towards individual and company objectives, training needs and development plans other than annually. Performance issues and concerns were also not formally discussed or recorded in this way. Formal on-going competency checks were also not being carried out to assess the care workers continual competence with tasks such as medicine administration and moving and handling. The care workers we spoke with confirmed they had shadowed an experienced member of staff and where applicable had received an annual appraisal but they were not aware of any regular supervision sessions taking place. This demonstrated the registered manager had not always ensured staff were prepared for the role, provided them with continuous formal support or ensured their competence was maintained.

This is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, entitled Staffing.

Some unannounced spot checks had been carried out by the office staff to ensure care workers delivered high standards of care. There was a plan in place to conduct these checks every three months or sooner if there were any issues raised. A care supervisor told us any issues raised at a spot check would be initially addressed by themselves or escalated to a manager.

Following the inspection, the registered manager sent us information with regards to enrolling staff onto the 'Care Certificate' with an external provider to ensure a robust induction process is provided in the future. She told us that all staff employed since April 2015 who did not have previous experience or qualifications would be subsequently enrolled onto the course.

The staff we spoke with told us they felt supported in their role and said that they had undertaken relevant training which they felt enabled them to be confident when assisting people at home. A care supervisor told us, "I completed an induction course which included all mandatory training as well as some other training that was relevant to my role. I also had to do some shadowing. I feel I am very well supported and I also feel as though I support staff well." A care worker told us, "I think I've received all the training required to do my job effectively and to the best of my ability and I do feel supported, all I need to do is ask." However one care worker told us, when asked if they had received medicine awareness training, "[I've had] a little bit when I first started on my weeks training in July 2016." They added, "I haven't had any refresher training yet but always get help if I was stuck on anything" and, "Since July 2016 I have only had one spot check and that was yesterday."

One person told us, "They [care workers] work well with the district nurse, they seem to want to work as a team" and, "Their assistance and encouragement has helped to speed up my recovery". A relative told us, "The carers have very quickly learnt how to communicate with him [her son]; they can definitely understand each other very well" and, "They are all very efficient, and capable."

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. The service relied upon the local authority's community mental health care team to provide capacity assessments and inform them of people's mental health needs upon referral. The office staff told us that where people lacked the mental capacity to make particular decisions they had been supported by their relatives and external health and social care professionals to make decisions in their best interests. The service had not been involved in any formal best interests' decision-making meetings however they had attended a multi-disciplinary meeting [a meeting with various external professionals] with regards to a

person who was at risk from choking.

We discussed how the service ensured people had the capacity to consent to their care and treatment. We were told that the service would refer a person to the community mental health team if there were any doubt about the mental capacity of someone they supported. Office staff told us that some people's relatives had a Lasting Power of Attorney (LPA), although they were unsure if this arrangement was for health and welfare, finances or both as they had not seen the documentation. An LPA is a way of giving someone (usually a relative) the legal authority to make decisions on your behalf if you lack mental capacity at some time in the future or no longer wish to make decisions for yourself. The office staff said in future they would ask relatives if they could provide a copy of the LPA documentation to evidence that they had the right to make these decisions on behalf of their relative. We also discussed how one person's finances were in the process of being managed by the local authority under Court of Protection. The Court of Protection is a court established under the MCA and makes decisions on financial or welfare matters for people who can't make decisions at the time because they may lack capacity to do so. After this arrangement is finalised, the office staff will liaise with the local authority to ensure the person has enough food, clothing and their bills are paid.

Care workers supported people to maintain good nutrition and hydration. The people we spoke with had no concerns about the support they received with this. We saw evidence in care records that the service had considered people's nutrition and hydration needs and the daily notes demonstrated care workers encouraged people to eat healthy, well balanced meals. There was additional evidence in daily notes that a basic record of food and fluid intake was completed by care workers in order to have some oversight. Nobody who currently used the service was being monitored by external professionals such as GP's, nurses and dieticians in relation to their nutritional needs.

Care records showed the service involved external health and social care professionals when people's needs changed. The records showed that staff had made referrals to a variety of professionals such as, GP's, district nurses, social workers and occupational therapists. Records were made of any communication and progress or outcomes were recorded. Relatives confirmed they were kept abreast of any involvement of external professionals.

Good

Is the service caring?

Our findings

It was apparent from the conversations we had with people that they enjoyed an excellent relationship with their care workers. Comments included, "We have a good laugh, they are all lovely", "They look after me very well, they are happy people, always friendly, I would be lost without them", "They are all very caring and honest people", "The carers are so gentle with me, they do everything very nicely, they know how much pain I can be in" and, "Oh they are such a lovely set of girls." Relatives confirmed the positive feedback, one of which adding, "Absolutely fantastic, I wish I had these people [care workers] years ago" and "It's lovely to see his [her son] face light up when they come."

The service was very accommodating of people's needs and changes. People told us the office staff always tried their best to help and there was never a problem if a person needs to change an appointment time. One person told us, "The office staff are very helpful, they answer the phone quickly and try their best to sort out any problems. They always return calls." A relative said, "I think they are extremely well organised, I can make changes to the times with no problems". Through discussions we found that the service was flexible to suit people's needs and wishes. Care records confirmed this. Specific care workers were allocated to certain visits because people preferred those care workers or had specifically asked for them and visits were frequently re-arranged to make it more convenient for people who had appointments and social occasions.

The staff we spoke with and observed demonstrated caring and compassionate attitudes when we discussed people's care needs, their role and the tasks they supported people with. The service had received a lot of compliments, many of which we saw were displayed in the office. Thank you cards from people included comments such as, "Fab carers! I've gone from thinking, oh no new carers, to thinking how fabulous these girls are" and, "Friendly, efficient service for almost five years". A card from a relative read, "The work you do is fantastic, she [their mother] told me so many times how lovely you all were, I would recommend Everlasting Care to anyone." An external professional also complimented the service stating, "Brilliant service, carers were extremely patient, considerate, caring and demonstrated a lovely manner with the patient. A real professional caring image."

Discussions with the office staff and care workers revealed that people who used the service did not have any particular diverse needs in respect of the seven protected characteristics of the Equality Act 2010; age, disability, gender, marital status, race, religion and sexual orientation. We saw no evidence to suggest that people who used the service were discriminated against and no one told us anything to contradict this. Training records showed some staff had completed an awareness course in equality and diversity.

A relative told us, "Before they [Everlasting Care] took over his [her son] care the manager went through his care plan step by step, explained everything and discussed all of my concerns. We developed a care plan from the start, and we were fully involved." Care records showed people and their relatives had been involved in the care planning process. They had contributed to the information recorded about themselves such as likes, dislikes, interests and hobbies. Some people been asked to sign the documentation to consent to the care and support, although this was not always consistent nor did the records explain why people couldn't sign or why relatives had signed on their behalf. The office staff told us they would ensure

this was improved.

We reviewed a 'Service User Guide' and an up to date 'Statement of Purpose' which the service had produced and shared with people who used the service. These documents contained information about the company's values and the limitations of service. They explained what the 'service user' can expect from the company and how the service will be delivered. They provided information on quality assurance, complaints and useful contacts. Some of the company's policies were also included for people's information such as staff conduct, health and safety and confidentiality.

At the time of this inspection nobody who used the service required an independent advocate. An advocate is someone who represents and acts as the voice for a person, while supporting them to make informed decisions. The office staff told us that relatives usually acted in this role and sometimes the deputy managers or a care supervisor assisted people. The office staff told us they were aware of how to involve an independent advocate from the local authority if they thought it was necessary.

People's sensitive information was kept locked away at the office and copies were available in people's homes for care workers to access. Some care workers had completed an awareness course in respecting privacy and dignity. All staff were aware of the importance of maintaining confidentiality and privacy. The care workers we observed demonstrated to us how they implemented this into their role. We observed care workers maintained dignity and privacy such as closing doors and blinds and keeping intimate areas of the body covered over during personal care tasks. All of the people and relatives we spoke with confirmed that staff had treated them, their families and their homes with respect. One person said, "They are very good, they respect me and my home, they always make sure they clean up before they leave and ask if I need anything else."

Care workers supported people to develop and maintain their independence. We saw care workers encouraging people to do some tasks for themselves, assisting only when necessary. One relative told us, "They have helped build confidence; they all go the extra mile." At the time of this inspection the service was not supporting anybody with end of life care. The office staff were aware of and had recorded end of life wishes, preferences and 'Do Not Attempt Resuscitation' orders where people had shared these with them. They told us the service aimed to deliver continuity of care and work with other professionals to enable people to continue living safely at home until the end of their life if they wished.

Requires Improvement

Is the service responsive?

Our findings

Person-centred support plans had not always been drafted by the service. The office staff were able to show us some examples of their person-centred plans which specifically detailed the care given to an individual, however the records we examined did not routinely contain this level of information. Care files did contain copies of the local authority support plans which had been shared with the service at the referral stage.

We examined five care records which had been compiled to provide guidance for care workers to assist the people they visited. The support plans lacked sufficient personalised details such as preferences, routines, life history, family, hobbies and interests, likes and dislikes in order for a care worker to understand and familiarise themselves with the person before visiting. Only one of the five records reviewed contained an 'Everlasting Care' support plan. The deputy managers told us they would ensure all people had a personalised care plan put into place by delegating a caseload to each office staff member. The care workers we spoke with and observed knew people very well and delivered the care and support people expected to receive to meet their needs. One care worker said, "Everything we need is in the file [care record]" and "The office staff phones us beforehand if there is anything unusual that we need to know."

People's basic care needs had been assessed but were briefly documented. For example, one record noted a person required assistance with catheter care. There was no support plan drafted for catheter care and there was a briefly written risk assessment which did not detail any individual risks, control measures or actions for staff to take in the event of an incident. A second person's record stated, "Two carers for all calls due to behaviour." However there was no care plan or risk assessment drafted to address the behaviours which may challenge the staff. A third person's record noted, "A risk of choking due to putting inappropriate objects into the mouth." Again, there was no specific care plan or risk assessment to minimise the risk of choking and there was no copy of the local authority speech and language care plan which was referred to in the local authority support plan.

One person's support plan described their care needs relating to medicine administration. In the medicine risk assessment there was a sentence which read, "Level 3 [category of support required] due to storage in key safe." It was not clear from this document why the medicines were locked away and if this was due to a risk. In the copy of the local authority care plan individual risks had been identified and were documented regarding medicine overdose, diabetes, behaviours which may challenge the staff and smoking, however this information had not been transferred into individual risk assessments. Upon discussion with the office staff it was apparent that the care workers knew the person well and that the care being delivered was safe and appropriate. The office staff told us this support plan was not up to date as the person's care needs had changed and the documentation did not reflect the changes and the current level of assistance. They assured us this would be reviewed and updated immediately.

Only one of the five files examined contained evidence of people's needs being reviewed, reassessed and recorded. We considered that the review document in use was not sufficient enough to enable staff to undertake and record a thorough review of people's needs. We asked to examine five reviews which had been conducted recently. These documents contained questions about 'satisfaction of service received',

'whether care workers were presentable' and 'whether office staff communicated well'. We considered this to be more of a satisfaction questionnaire than a review of people's needs. We would expect to see that the office staff had discussed people's current care needs and the service delivered. We would also expect to see that care needs were individually explored to ensure care workers were meeting the objectives people wanted to achieve and that any changes were documented. One person's medicine support plan had a review date of three months due to level of support required, however it had not been reviewed since it was written in September 2016. The office staff told us this person's needs had changed and a review would take place immediately to reflect the changes.

This meant care workers were not always provided with full written instructions around the individual support people currently required and how people would prefer the support to be delivered. We discussed our findings in relation to the support plan, risk assessment and review documentation with the office staff and later with the registered manager. Following the inspection, they sent us an updated version of the risk assessment and review forms which included a more thorough approach to assessing and reviewing people's individual needs.

We recommended the service took a more person centred approach to care planning and risk assessing and that office staff and care workers contributed to reviewing care needs in order to provide thorough, personalised details about individuals which are up to date.

Two local authority care managers shared examples with us which demonstrated the service had been responsive to people's complex needs. One said, "They [the service] are working with me with a terminally ill person, they have provided great feedback, they give me an accurate picture of changing needs, they have worked with external teams and managed to reduce the level of care required. The person is responding to treatment better and the prognosis has improved. The second care manager said, "They [the service] are temporarily covering 24 hours a day until medical issues are resolved. They were able to change the plan of care immediately. They changed hours and times at short notice and have engaged with me throughout the process. They have ensured a manager is at any meetings as well as the care workers."

Care workers described to us how they ensure people are given choice and control over all aspects of their care. They told us they asked people what they wanted. For example they might ask about food, drinks, clothing and toiletries. They told us people usually had a set routine but they always checked. People told us they could choose if they preferred a male or female care worker and that the service had respected other choices such as what time they liked to get up and what time they liked to go to bed.

The service had received five complaints since our last inspection. Complaints had been investigated and responded to by the registered manager. We saw initial acknowledgements had been made in a timely manner and the company complaints process was followed correctly. The office staff told us they dealt with smaller issues immediately which could be resolved easily over the telephone or by making a visit to the person.

A complaints policy and procedure was in place and had been shared with the people who used the service via the 'service user guide' and 'statement of purpose'. The people and relatives we spoke with during the inspection had no complaints about the service, the care workers or the management. One relative said, "They have been very responsive about comments I have made about their approach to my wife's care" and "They are very good I have no complaints at all". Everyone we visited was also very complimentary about the service. Their comments included, "They are very efficient and don't leave until everything is right", "No problems at all", "No complaints whatsoever", "Never had to complain about anything" and "Absolutely fabulous, nothing is a bother to them."

Requires Improvement

Is the service well-led?

Our findings

A deputy manager was in charge of the service upon our arrival and assisted us throughout the inspection with the help of a second deputy manager and a care supervisor. They liaised with care workers and the people who used the service on our behalf. The registered manager was on annual leave at the time of our inspection but we spoke with her on her return and she provided us with further information.

Some audits and formal checks on the safety and quality of the service were being carried out, namely spot checking of service delivery and checks on the care records kept in people's homes. We reviewed five 'file checks' which were dated 4 April 2017. They highlighted issues such as "positional charts required in [person's name]" and "support plan, moving and handling plan and personalisation needed in [person's name]"; although these documents had been identified as missing from files, action had not yet been taken to address the issues. We also reviewed three 'spot checks' dated in March 2017 which highlighted that care workers had been observed without disposable aprons on. The form was a basic 'tick box' form with no place to explain which tasks were observed or who was going to deal with any issues raised. Again, although issues had been identified these checks had not yet been seen by a manager in order to address the issues.

When we discussed the lack of personalised support plans and risk assessments drafted by the service with the office staff, they were partially aware of the missing information and what was required. The office staff had started to draft some personalised support plans for people which we were able to see however they had not fully identified all of the shortfalls we highlighted with documentation such as the omission of individual risk assessments of people's specific needs.

Training and induction not had been robustly monitored; this had allowed some staff to continue working without completing a formally assessed common induction package, such as the Care Certificate. There was also a lot of staff who had not been recently refreshed in topics such as safeguarding vulnerable adults, food hygiene, infection control and health and safety. Training in topics such as dementia awareness, epilepsy, diabetes and challenging behaviour had not been routinely sought for care workers who were supporting people with these needs. This meant the registered manager had not assured herself that all new care workers were competent to carry out their role prior to being allowed to work unsupervised or that established care workers were kept up to date with current best practice or provided with training to meet peoples individual needs. Following our inspection, the registered manager informed us she has enlisted the services of an external training provider to undertake the 'Care Certificate' with all new staff and provide training sessions on specific topics.

Through our conversations with the office staff, we noted there was no formal daily record of the out of hour's service. The deputy managers and care supervisors worked on a rota basis covering the service outside of normal office hours. They told us they verbally told each other what had occurred during a handover process between shifts or text information to each other via a mobile phone. They did complete a basic weekly handover form. We discussed this with the deputy managers and registered manager who confirmed there was no robust written record of communications with people and staff outside of office hours. The deputy managers told us the care workers text them whilst they was off duty with anything

important that they needed to know. We asked the deputy managers to consider the implementation of a 'handover' record to ensure important information is passed between staff on differing shifts and that information is signed for when actioned to confirm who has taken responsibility for addressing the issues raised. The registered manager also agreed this would ensure staff were accountable for their actions and responsibilities. We saw this was implemented by the end of the inspection.

Although accidents, incidents and safeguarding matters were low and recorded appropriately they had not being formally analysed for oversight of the service. Trackers or contents lists were not included at the front of records to help the registered manager identify patterns or trends. Neither the registered manager nor office staff had devised any actions plans following their checks of the service.

We considered that overall service monitoring and record keeping required improvement. Although the office staff were able to explain most things we enquired about, there was a lack of formal documentation to demonstrate their compliance with the regulations.

We recommended the registered manager reviewed their policy with regards to monitoring the quality and safety of the service and record keeping.

Management meetings had taken place in the past to discuss the safety of the service. However these were not routinely scheduled and no meetings had taken place since May 2016. The last staff meeting was held in November 2016. This meant that staff had not had a regular opportunity to meet formally with their managers and discuss aspects of the service, share best practice or be involved in the development of the service. No action plans had been drafted to address issues raised in any of the meetings we reviewed.

Although annual appraisals were in place, regular one-to-one supervision sessions had not taken place. This meant staff had not had an opportunity to meet with their manager on an individual basis to discuss their role, objectives, training needs and development. We spoke with the office staff about this and they told us that care workers came into the office whenever they liked to discuss issues but nothing had been formally recorded. Care workers confirmed that they felt confident to approach the office staff or registered manager to discuss anything that concerned them but also said regular formal supervision sessions did not take place. The registered manager later informed us that supervision sessions had been introduced for all staff.

The registered manager had extensive experience of working with adults in a nursing and domiciliary care setting. The deputy managers had progressed through the organisation into their current roles. The deputy managers were very knowledgeable about the people who used the service and had provided personal care and support to everyone who currently used the service. One person told us, "Often the manager calls out to help with care, I think this very good". Another said, "The manager and deputies come out a lot."

There was a clear staffing structure in place, which included the registered manager, two deputy managers, an administrator, care supervisors and approximately 30 care workers. The whole team were aware of their responsibilities and what they were accountable for. The care workers worked regular shifts which were consistent for both them and the people who used the service. The care workers we spoke with told us they had no issues at all with the management of the service. Policies and procedures were available and a periodic reviewing process was in place.

The culture of the service was open and transparent. During the inspection and afterwards during feedback, the office staff displayed openness and transparency towards the evidence we presented to them and in their responses to our findings, as did the registered manager.

The people, relatives and professionals we spoke with described the service using words such as "Excellent", "Absolutely fantastic", "Brilliant" and "Nothing but great." Staff told us, "Yes I am fully supported at all times", "This company look after their staff as best as they can. Nothing is too much of an issue, all you need to do is ask", "All managers are very approachable and are competent in what they do. I would have no issue on concerns not being addressed" and "I feel personally, that I could contact the manager, deputy managers or supervisors with any concerns and they would be addressed accordingly." We asked care workers if they enjoyed their job. One said, "I feel that coming to this company was the best decision I ever made". Another said, "I am happy with whom I work for and I am happy in my job."

The service had attempted to seek the views of people who used the service by sending out an annual satisfaction survey. They told us they had not received any real results to gauge a proper opinion of the service. Feedback from people was also gathered at care reviews and spot checks. Feedback we reviewed about the service was overwhelmingly positive with the odd comment about care workers running late on occasions. The service had not formally sought the views of their staff but the deputy managers told us this was something they could implement straight away.

The office staff told us about the challenges of running a domiciliary care agency and had found that the service faced similar difficulties which are recognised across the industry. Recruitment of good staff and travelling distances for care workers were some of the issues they faced. The deputy managers told us about strategies the company had tried to attract and retain good care workers into the business including a higher rate of pay, guaranteed hours, travelling costs and handing out small token gifts to staff named in compliments. Care workers told us they had recently received a pay rise and that the office staff made a conscious effort to limit the distance they travelled. This demonstrated the registered manager listened to the views of staff and attempted to resolve issues that were important to them.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Personal care	Regulation 18 HSCA RA Regulations 2014 Staffing New staff were not fully prepared for their role through a robust induction programme such as the 'Care Certificate'. Formal competency checks of staff were not carried out for all aspects of their role. Training in key topics was not up to date. Specific training to meet the complex needs of some people who used the service was not routinely provided to staff to enable them to have the necessary skills. Regulation 18 (1)(2)(a)