Individual Care Services

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Inspection report

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Date of inspection visit:
19 July 2016

Date of publication:
17 August 2016

Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We inspected this service on 19 July 2016. The inspection was announced. The service is registered to deliver personal care in people's own or shared homes, and provides an assisted living service.

There was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like 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 service is provided for younger adults who may live with learning disabilities, autistic spectrum disorder, a physical disability or dementia, at thirteen different houses. At the time of our inspection, fifty-seven people were receiving an assisted living service, but only nine people received assistance with personal care, which is the regulated activity covered by the Health and Social Care Act 2008, that we regulate.

People were safe and were protected from the risks of abuse. Staff were trained in safeguarding and understood the action they should take if they had any concerns that people were at risk of harm. The registered manager checked staff's suitability to deliver personal care in people's own homes during the recruitment process.

Care plans included risk assessments for people's individual health and wellbeing and described the actions staff needed to take to minimise the identified risks. Staff understood people's needs and abilities because they read the care plans and shadowed experienced staff when they started working for the service.

The registered manager assessed risks in each person's home and advised staff of the actions they should take to minimise the risks. People's medicines were administered safely because the provider's medicines policy included training staff and checking that people received their medicines as prescribed.

Staff received training and support that enabled them to meet people's needs effectively. Staff had opportunities to reflect on their practice and consider their personal career development.

The manager understood their responsibility to comply with the requirements of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). Records showed that people, their families and other health professionals were involved in making decisions about their care and support. Staff understood they could only care for and support people who consented to being cared for.

Staff referred people to healthcare professionals for advice and support when their health needs changed, and supported people to follow the health professionals' advice.

People told us their care staff were kind and understood them well, so they felt like friends. The provider asked people about their preferences, likes and dislikes for care and support during their initial assessment

of needs.

People told us staff respected their privacy, dignity and independence, and they were supported to life the lives they wanted. People knew any concerns or complaints would be listened to and action taken to resolve any issues.

People were encouraged to share their opinions about the quality of the service through one-to-one conversations with a member of the management team.

The staff and management team shared common values about the aims and objectives of the service. People were supported and encouraged to live as independently as possible, according to their needs and abilities.

The provider's quality monitoring system included regular checks of people's care plans and staff's practice. When issues were identified the provider took action to improve the quality of the service people 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?

Good

The service was safe. Staff understood their responsibilities to protect people from the risk of harm. Risks to people's individual health and wellbeing were identified and care plans explained how to minimise the risks. The provider checked staff were suitable to deliver care and support to people in their own homes. There were enough staff to support people safely. The provider minimised risks to people's safety in relation to medicines.

Is the service effective?

Good

The service was effective. Staff were skilled and trained to meet people's needs effectively. Staff understood their responsibilities in relation to the Mental Capacity Act 2005 and supported people to make their own decisions. People were supported to maintain their health and staff involved other health professionals in people's care when needed.

Is the service caring?

Good

The service was caring. Staff knew people well and understood their likes, dislikes and preferences for how they wanted to be cared for and supported. Relatives and healthcare professionals told us staff were caring and respected people's privacy and promoted their dignity and independence.

Is the service responsive?

Good

The service was responsive. People decided how they were cared for and supported and staff respected their decisions. People and staff were confident that complaints or concerns would be dealt with promptly and resolved to their satisfaction.

Is the service well-led?

Good

The service was well-led. People were encouraged to share their opinion about the quality of the service, to enable the provider to make improvements. Care staff felt supported by the management team, which motivated them to provide a good quality service. The provider made changes to improve the quality of the service and to improve how staff were supported.

Individual Care Services

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 19 July 2016. The registered manager was given 48 hours' notice of the inspection, because they provide personal care in people's own or shared homes, and an assisted living service. We needed to be sure that someone would be available at the office to speak with us. The inspection was undertaken by one 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.

We reviewed the information we held about the service. We looked at information received from the local authority commissioners and the statutory notifications the registered manager had sent us. A statutory notification is information about important events which the provider is required to send to us by law. Commissioners are people who work to find appropriate care and support services which are paid for by the local authority.

We reviewed the information the provider shared with us prior to the inspection in the provider information return (PIR). This is a form the provider completes to give some key information about the service, what the service does well and improvements they plan to make.

Prior to the inspection site visit, we sent questionnaires to 11 people who use the service, 11 relatives, six healthcare professionals and to all of the staff. Their responses are included in our findings.

The service is provided for younger adults who may live with learning disabilities, autistic spectrum disorder, a physical disability or dementia, in their own or shared homes. At the time of our inspection, nine people received assistance with personal care, which is the regulated activity covered by the Health and Social Care Act 2008.

Three of the nine people were not able to speak with us because of their complex needs and three other

people did not want to speak to us about their care and support. We spoke by telephone with two people about how the service supported them and one relative spoke with us on behalf of their relation who received care and support. We also spoke by telephone with four support workers and a supervisor. We spoke face-to-face with the registered manager and the quality and compliance manager.

We reviewed four people's care plans to see how their care and support was planned and delivered. We checked whether staff were recruited safely and trained to deliver care and support appropriate to each person's needs. We reviewed the results of the provider's quality monitoring system to see what actions were taken and planned to improve the quality of the service.

Good

Is the service safe?

Our findings

Both people who spoke with us by telephone spoke openly in the company of staff who supported them throughout the call. This demonstrated they trusted staff and felt safe with them. A relative told us they thought their relation was safe with staff, because they always presented the same moods and behaviours. This indicated they were not anxious or worried about anything.

People were protected from the risks of abuse because staff understood their responsibilities to keep them safe from harm. Staff told us they had training in safeguarding. Staff told us, "It's about keeping the person safe, seeing signs of potential abuse, bruises for example" and "I would see the signs in the person's appearance or emotional state." Staff told us they had no concerns about people being harmed, but they knew what to do if they had. Staff told us the provider's whistleblowing policy gave them confidence that any concerns would be taken seriously and dealt with by the registered manager. The registered manager had not needed to notify us of any referrals to the local safeguarding team in the previous 12 months.

Records showed the registered manager completed risk assessments that were relevant to people's unique needs and abilities. For example, risk to people's nutrition, mobility and communication were identified and their care plan included guidance for staff to minimise the identified risks. The guidance included the equipment needed and how to complete the required tasks safely. Staff told us they read the care plans and daily records, and worked with the same people regularly, so they knew how to support people safely.

Care plans included risks related to the person's home and the equipment they needed. There were clear instructions and guidance about the actions staff should take in an emergency, including personal emergency evacuation plans. A member of staff told us, "We have contact numbers for emergencies. They are in the care plans for GPs, district nurses and equipment repairs." The risk assessments and care plan were clearly effective as the registered manager had not needed to notify us of any accidents in the previous 12 months.

Staff were allocated and recruited dependent on the individual needs and abilities of people who received the service. Staff told us there were enough staff available to support people in accordance with their care plans. Staff had no concerns about being short-staffed due to unplanned absences, such as sickness absence. Staff told us there was always someone around for support and guidance in an emergency. A member of staff told us, "The on-call system works. I phoned once in the middle of the night and it was answered straight away. I got the guidance I needed. They came out the next day to check it was all okay."

The provider's recruitment process included ensuring people were protected from the risks of being supported by unsuitable staff. The registered manager checked staff's suitability to deliver personal care before they worked with the person. Records showed staff completed an application form, which detailed their background, personal experience and knowledge of health and social care. The registered manager checked with staff's previous employers and with the Disclosure and Barring Service (DBS), to make sure they were suitable to work in people's own homes. The DBS is a national agency that keeps records of criminal convictions.

People's medicines were managed and administered safely. People did not want to talk about their medicines, and we were not able to look at their medicines administration records (MARs), because the records were kept in their own homes. Supervisors checked people received the medicines they needed by reviewing the MARs and reporting any issues to the registered manager. We looked at records of the checks made by the supervisors and asked staff whether they had any concerns about the medicines administration systems.

Staff told us only trained staff administered medicines and they had to be signed-off as 'competent' after their training. Staff told us, "[Name] has medicines first thing and at six. It's fine, it's never a problem." A supervisor told us, "I check MARS and count the amount of medicines left. I have not found anything major in my checks." The supervisors' records showed they observed staff's practice, checked that records were signed and up to date, and the amount recorded matched the actual amount remaining. They checked that medicines were safely locked away, kept at the recommended temperature, and that staff marked bottles and creams with the 'opened' date, to ensure they were used within the recommended timeframe and remained effective.

Good

Is the service effective?

Our findings

People told us staff were effective, because they were supported in the way they wanted. They told us staff understood the things they could do for themselves and the things they needed support with. A relative told us they believed the staff had the 'right' skills, because their relative was supported to maintain their independence in their preferred way. A healthcare professional who responded to our survey said the service was one of their, "Most trusted agencies", because staff worked well and "Within the guidelines for people's clinical needs."

Staff told us they felt confident and fully prepared to work with people, because their induction programme included shadowing experienced staff, getting to know the people they would work with and training. A member of staff told us, "New staff observe by shadowing on several shifts before working independently. Their competence is checked. They start work when they feel ready." Records showed new staff were checked and signed-off as 'competent' against a list of criteria, which included staff's understanding of people's individual needs and abilities and how to support them effectively.

All new staff received training that was relevant to supporting people, for example, in the Care Certificate, first aid and moving and handling and achieved the Care Certificate. Staff told us they also received training in subjects specific to the person's needs, such as, training in epilepsy, autism awareness and how to support people who present challenging behaviour. A member of staff told us, "I have learnt distraction techniques for when people present behaviour that challenges." They told us the techniques were effective at supporting the person to 'think about things differently'.

The registered manager planned for all staff to complete training to achieve the Care Certificate. They said this would ensure all staff understood the fundamental standards of care that people should expect to receive from the service, and to ensure their practice was in accordance with the most up-to-date guidance. One member of staff told us, "I attended a week-long training in the Care Certificate. It was a useful refresher course."

Staff told us they received support and supervision from the team of field care supervisors. Staff told us, "I have a named supervisor and I know which week we will have a meeting" and "I see the field care supervisor quite a bit. I have been observed in practice. They watched what we did and how we spent the day. I got good feedback on how I approach [Name]." Some staff who had recently transferred from another provider were less familiar with, or confident about, their supervisory arrangements. The registered manager had scheduled 'meet and greet' sessions between supervisors and staff as an introduction, followed by more formal one-to-one meetings and observations of staff's practice. Staff told us some 'meet and greet' sessions had already taken place and they were happy with the arrangements for the future.

Staff were encouraged and supported to consider their own professional development. Following a management restructure, there were opportunities for staff to take on the newly created 'field care supervisor' roles, which included more responsibilities. The new role replaced the previous positions of 'group leader'. A member of staff told us, "I get lots of support. I was a group leader, responsible for one

house, now I see care across a group of houses. I was ready for the change. Everyone has been very accepting, very supportive."

We checked whether the service was working within the principles of the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS). The MCA provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). We checked whether any conditions on authorisations to deprive a person of their liberty were being met. The registered manager understood their responsibilities under the Act. The registered manager had applied to the Supervisory Body for the authority to deprive a person of their liberty, because they did not have the capacity to understand the risks related to some of their decisions.

Care plans included assessments of people's capacity to make decisions about their finances, health and safety and their physical health and wellbeing. The registered manager ensured people were supported to make decisions, either by a person who was already appointed as the 'attorney' for the specific type of decision, or they arranged for an advocate to support them. An advocate is an independent person who is appointed to support a person to make and communicate their decisions.

Staff understood and acted within the principles of the Act, by supporting people to make their own decisions. People told us they chose where to go and what they wanted to do. One person told us, "I like to go to bed at 9pm and [Name of staff] remembers that." Sometimes, when we telephoned to speak with people, staff answered the phone because the person had decided to have a 'lie-in' that day. We heard other people telling staff, they did not want to speak with us. People chose whether they called us back or not. A relative told us they were confident their relation made their own decisions about their everyday life, because, "[Name] is always in a reasonable mood when I go round", which they felt was a sign the person was not frustrated by a lack of choice.

People were supported to maintain a healthy diet and to eat regular meals of their choice. People told us they ate what they wanted and when they wanted. One person told us, "I am going out for breakfast and we are going to [Name of supermarket] after." Another person told us about their favourite meals and told us staff 'knew' what they were. Staff told us people's care plans included suggested weekly menus that met people's preferences.

People were supported to eat and drink enough for their needs and to minimise risks associated with poor nutrition or hydration. People's care plans included their likes, dislikes and preferences for eating and drinking. People's risk assessments identified any areas that could impact on their ability to maintain a healthy diet. For example, for one person who was identified as 'at risk' of the impact of poor hydration, their care plan advised the minimum volume of fluid the person should drink and described the type of cup the person could use independently. The care plan instructed staff to 'cut up' the person's food, and to make sure they used specially adapted plates and cutlery. The care plan promoted the person's independence and ensured the person gained maximum satisfaction from each meal.

Records showed people were referred to healthcare professionals, such as dieticians and speech and language therapists, to ensure any physical difficulties with eating and drinking were identified and

supported. Care plans recorded the outcome of the professionals' assessments and the actions they recommended. Records showed staff supported people to follow the advice. For example, following a visit by a dietician, one person had agreed to follow a 'healthy eating plan', and their weight had subsequently changed to a recommended level for their height. A supervisor told us, "Staff would call the person's GP for health needs, but I expect them to report if people need referring to specialist healthcare services."

People were supported to maintain their health and were supported to visit healthcare professionals when needed. One person told us, "They look after me. I see my GP. They are pleased I am walking about now. I like walking about." A relative told us, "They organise a GP when needed and always let me know." Staff told us healthcare professionals visited people in their own homes, if that was more appropriate. A member of staff told us, "The district nurse visits [Name] regularly and arranged for replacement equipment."

Staff worked with healthcare professionals to achieve the best possible outcome for people. A healthcare professional responding to our survey told us, "Staff work very well to a psychological model. They keep good records and follow behavioural guidelines well." Staff monitored the impact of changes in how they supported people following the advice of healthcare professionals. Records showed staff notified the healthcare professionals about the impact of the changes and planned the next steps together to ensure the person's health was maintained.

In the provider information return the provider told us they were developing 'hospital passports' for each person. A hospital passport includes all the relevant information a hospital or external provider might need to care effectively for a person at short notice and in the event of an emergency. During our inspection we saw the registered manager had made progress with this plan. One passport we looked at for a person who was not able to express themselves verbally, explained what they might think or feel, according to the gestures they made. This meant that people will be supported effectively, by health professionals, even if they do not know them personally.

Good

Is the service caring?

Our findings

People told us the staff were kind because, "They are my friends" and "They help me. They look after me." A relative told us, "The current staff are very good. There is lots of communication between them. They know [Name] well, their moods and behaviours." A member of staff told us, "Staff are really caring. People are truly involved. They get on really well."

People we spoke with knew the names of their support staff and knew their individual interests. For example, one person knew which member of staff most enjoyed supporting them in maintaining their garden. The registered manager made sure people enjoyed a continuity of care by allocating a team of staff to support each person regularly. This ensured people were supported by staff they were familiar and comfortable with. Some staff told us they worked with the same people 'for years', so they understood the progress people had made and understood the barriers to people achieving full independence.

Staff told us people's medical condition or mood could be a barrier to their independence, and their role was to support people to overcome the barriers. Staff saw their role as helping people to understand the importance and value of living independently. One member of staff told us, "I persuade and reason with them when they do not want to do something, as you would with anyone. It's not always something you want to do (shopping), but something you need to do, so you aren't hungry." The member of staff told us one person's goal, as identified in their care plan was, "To sustain their independent living as long as possible."

People's care plans included a personal profile, which explained their history, medical conditions needs, abilities and preferences. The information included people's cultural and religious beliefs and traditions, so staff knew what was important to people and how best to support them to follow their religious practices. Staff told us they supported people to maintain their cultural routines and these were planned for in people's individual 'activities planner'. A member of staff told us, "We respect people's view and religious beliefs. I go to church with [Name], when they want to go. They don't discuss their beliefs, but they go to the church."

A relative told us staff understood their relation well and responded appropriately to their needs. They said, "They have been supporting [Name] for years. [Name] is happy and in a 'steady state'. They help him maintain his lifestyle."

One person told us staff supported them with maintaining the way they wanted to look. They told us staff supported them with washing and ironing their clothes and visiting the barber. They told us, "I am getting my beard trimmed next week." They told us they liked having a beard, but only if it was trimmed. Care plans included guidance for how staff should support people to maintain their dignity, choice and independence. For example, care staff were instructed how to support people to choose their own clothes and hairstyle, to suit their preferences." A member of staff who responded to our survey commented, "ICS respect the beliefs of its service users and service users can have a choice of things they want to do."

Staff told us they respected people's right to privacy. We heard staff ensured people decided for themselves whether they wanted to talk on the telephone with us about their care and support, and staff respected their decisions. Staff told us people's plans and daily records were confidential and kept in the locked staff room out of sight of other people.

Good

Is the service responsive?

Our findings

People told us they were supported to go out and about where and when they wanted. A healthcare professional who responded to our survey commented that the managers and staff had "Good communications" and said, "I know that if I have any concerns I can address them with managers and my concerns will be taken seriously."

A relative told us, "They involve me in the care plan and review." Records showed people's care plans were regularly reviewed and updated when their needs and abilities changed. One person's care plans and risk assessments showed they needed to move to more suitable accommodation, following a change in their abilities. The registered manager told us the organisation planned to buy an appropriate property for the person, "In whichever town [Name] chooses". The person was being supported by an advocate, to consider the advantages and disadvantages of two different towns.

People's care plans included their aims, such as, to maintain and increase their independent living skills. One person's goal was clearly described as, "To continue to live independently as long as possible." The care plan described how to support the person with their physical and emotional needs and the actions staff should take to enable the person to lead a fulfilling life. People told us about the domestic tasks they could do for themselves and those staff supported them with, which matched the information in their care plans. One person told us, "[Name] helped me do my washing. It is hanging outside now" and "[Name] did my garden for me."

People were happy to tell us about the places they liked to visit, such as the library, the shopping centre and the local garden centre and cafes. They told us staff supported them to visit their preferred places. One person told us their preferred routine was to visit the library several times a week, and we saw this was included in their personal profile. Staff were supported to understood and respect the things that were important to people, because their care plan clearly stated, "Do not joke about" and "Routine fixed by [Name]. Do not change."

A member of staff told us one person did not have many visitors, but said, "We team up with people from another house and have a day out together", which promoted the feeling of belonging to a community. A relative told us they visited whenever they wanted and their relation was supported to live 'an ordinary life' and to be a part of their community. They told us their relation was supported to do their own shopping, to go for walks in the park and to take a holiday every year. The relative told us, "[Name] goes on holiday every year with staff. It stimulates them. They look forward to it." A member of staff told us people were supported to take ownership of how they lived. They told us, "The house has recently been decorated. People chose the paint colours, carpets, lampshades, bedding and kitchen utensils."

Staff told us they shared information verbally at the end of their shift and kept a written daily log, so all staff knew of any changes in a person's needs or plans for the day. We were not able to see people's daily records as they were written in books, which were kept in people's own homes. A member of staff told us, "We are going to change from books to loose leaf sheets for recording. It will all be in one folder, which will be easier

for us staff." This will ensure care plans remain relevant so staff can respond to changes in people's needs.

One person told us, "I am never worried about anything. I would talk to [Name] or [Name] if I was. They are my friends." A relative told us, "I know who to complain to, but can't remember when I last complained." The provider had made their complaints policy accessible to people by including a copy in their care plan in an easy read format.

People we spoke with did not have any complaints about the service. The registered manager had not received any formal complaints about the service, but had acted on concerns when they were raised. We shared some feedback we had received from our survey and the manager was able to tell us the actions they had taken and what they had learnt from the concerns that were raised. A healthcare professional told us they had no concerns or complaints about the service, because any concerns were acted on promptly.

Good

Is the service well-led?

Our findings

A relative and healthcare professional told us the service was well-led. The relative told us, "They are very approachable. They listen and sort things out. They keep in contact by phone." A healthcare professional who responded to our survey commented, "Over the years I have been impressed with their management, recruitment of good care staff, and by the quality of care they provide." In response to our survey a member of staff commented, "All staff are caring and we all work well as a team."

The provider had taken action to support improved visibility of and access to the management team, with clearer lines of accountability. Several changes had been implemented in the management structure during the previous six months. The registered manager had been appointed in May 2016 and several care packages and staff had recently transferred from another provider during February 2016. Some roles had become redundant and new roles of 'field care supervisors' had been created. This meant there had been opportunities for staff to develop their skills and responsibilities, and to consider their career development.

Most staff told us they had felt well-supported throughout the changes and had already seen some benefits. Staff told us, "The new structure seems good. Once it is up and running I think it will work well" and "Restructure seems fine. I've not had a problem with it. It seems more about the back office, but transition can be difficult." Another member of staff said, "We have new bosses. I think there wasn't enough feedback to staff, not enough support or praise and morale was low. We wanted change, but change is unsettling."

The registered manager and provider understood that implementing changes could be unsettling and had taken action to re-assure staff about the purpose and intended impact of the changes. They had sent a letter to each employee, explaining the new structure, created new job descriptions, which clearly stated their responsibilities, and arranged training for the field care supervisors. The provider had scheduled a series of 'meet and greet' sessions and planned a series of 'roadshows' for staff to explain their values, aims and objectives for the service and to invite feedback from staff.

Staff told us the 'meet and greet' sessions and regular one-to-one meetings were useful as it gave them an opportunity to voice any concerns. A field care supervisor told us, "The change in management structure is good. I started in the role in April and have attended two meetings so far. Everyone seems settled, seems happy with the new arrangements."

People were asked for their views of the service at one-to-one conversations with the quality and compliance manager, during their regular service audits The 'health and wellbeing' section of the service audit included a series of questions and observations about the person's appearance, routines, environment and whether the person was happy with their care. No-one we spoke with wanted to talk about the service audits, but they were confirmed they were happy with how they were cared for and supported. A relative told us they thought, "There is nothing to change. There is nothing to improve in the service."

The quality and compliance manager explained the ethos of the service was, "About the whole person. Staff are not parents, their role is to enable people." Staff shared the same values and objectives and spoke

enthusiastically about people's chosen lifestyles and personalities. Staff told us the provider responded to feedback and took action to improve people's experience. For example, they told us how people had been involved in recent redecoration work at one of the houses. Staff told us, "We got a new whiteboard for [Name] to help them keep track of their weekly plans."

Staff told us they felt empowered to sort out 'local' issues between themselves. A member of staff told us, "There were a few issues with staff not cleaning and keeping the house tidy, so we implemented a rota for this house. It meant more sharing, but it worked. The house is kept cleaner now."

The provider's quality monitoring system included regular checks of people's care plans, medicines administration and staff's ongoing suitability for their role. The quality and compliance manager shared the results of their checks with the registered manager and field care supervisors, which resulted in action plans and timescales for improvements being agreed. Actions included refresher training for staff and regular checks of their practice, to ensure their competence was monitored. A member of staff told us, "I see the field care supervisor quite a bit. They sign off the medicines administration and get cash out. Any problems and they will come over straight away. They are very helpful."

The registered manager told us they were in the process of implementing a new system for people's daily records and financial transactions, to support more frequent audits of people's health, wellbeing and financial security. They had changed from a 'book form' to 'loose leaf' sheets, which were collected from each house, while allowing staff to maintain a continuous daily record. This will make it easier to identify changes in people's needs or abilities.

The provider took action to continuously improve the service. In the provider information return, the provider told us they planned to introduce an electronic monitoring system, which will simplify procedures for staff signing in and out, will confirm the number of hours staff work and will provide a 'real time overview on care visit status'. The registered manager explained this meant they will know immediately whether staff arrive at their allocated destination on time or not. They told us if staff did not log in electronically at the expected time, they could call staff to find out whether there were any problems to be resolved.

At the time of our inspection visit, the system had already been implemented at some people's houses. Staff told us, "The new phone system, (electronic call logging) is very good" and "We will have the new electronic signing in. Once it is running, we won't have to do timesheets." Records showed the provider had obtained people's consent to electronic call monitoring equipment being installed at their houses and for staff to recharge their mobile phones while on duty, to ensure they were always contactable by the manager.

The registered manager understood their legal obligations. They had prepared for our inspection visit by talking with the management team and gathering all the supporting documentation they thought we might want to look at. They had kept copies of the statutory notifications and other information they had shared with us in the previous 12 months. They had arranged for staff training in the fundamental standards of care and staff's effectiveness and competency assessments included feedback from people who used the service. This meant people were at the heart of the service.