L S Care Limited

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Inspection report

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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?	Good
Is the service well-led?	Good

Overall summary

This inspection took place on 21, 22, 28 and 29 September 2015. The inspection was announced.

We last inspected the service on 12 September 2013 and found they were meeting all legal requirements inspected against.

L S Care Limited provides nursing and personal care for people living in their own homes, some of whom have complex health needs. At the time of the inspection they were supporting 38 people living across Northumberland, North Tyneside, South Tyneside, North Tyneside and Gateshead. Some people received care and support 24 hours a day whilst other people had visiting support.

There were two registered managers in post at the time of the inspection. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered

Summary of findings

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 coding of medicine administration was not always completed in line with the medicine administration recording. One person receiving care was deciding when they needed to take a routinely prescribed medicine which meant they were not receiving it in line with the prescriber's instruction. For another person we found that the provider had failed to ensure they had an appropriate supply of their prescribed medicines. A registered nurse had then administered crushed tablets via a PEG tube. This method of administration had not been prescribed for the person.

For some people consent for care and treatment was given by relatives however we did not see any evidence of mental capacity assessments or formal best interest decisions. The registered manager said, "We should focus more on best interest decisions and mental capacity in the care plans."

Care plans and risk assessments were person centred and focused on the specific needs of each individual. We found that some care plans were unclear on the frequency that certain checks needed to made, for example when people where spending time alone, and when checks on continence and skin integrity should be made. This meant staff could be completing checks at different intervals which potentially left people vulnerable. The registered manager told us that care plans were a "Work in progress". They offered reassurances that specific information would be added about the frequency of checks.

Staff were pro-active in seeking the advice and guidance of healthcare professionals in relation to people's complex needs, including nutrition and continence.

People told us there were enough staff to meet their needs and they were happy that they had their own core staff team who knew their needs and were appropriately trained to care for them. People and their relatives said were caring and compassionate and respected their privacy and dignity.

Staff recruitment was robust and once in post staff received relevant training which ensured they could meet the specific needs of the person they were caring for. Supervision and appraisal were held on a regular basis and staff said they felt well supported.

Staff knew how to report any concerns in relation to safeguarding and accidents and incidents. All events of this nature were investigated and discussed by the provider in quality meetings.

Quality meetings also included a review of the questionnaires sent to staff and people using the service and any improvements to quality or changes to practice. The provider did not have a system for sharing overall findings with people and the registered manager said, "We could tighten up on things." They went on to say that the newsletter provided an opportunity for them to share findings and actions with people and staff.

People and their relatives were encouraged to be involved in the development of their care and support and people knew how to complain if their needs were not being met. We saw that records of complaints were kept, fully recorded and investigated and people were kept up to date with outcomes and changes to procedures. People also received apologies where necessary.

Audits were completed and included actions that needed to be taken which were discussed in the quality meetings.

You can see what action we told the provider to take at the back of the full version of the report.

Summary of findings

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.

People were not protected from the risks of unsafe administration and recording of medicines.

Staff understood safeguarding and how to report concerns.

People said they had their own team of staff which was enough to ensure their needs were met.

Recruitment procedures were robust and checks were made before staff started their employment.

Is the service effective?

Requires improvement 

The service was not always effective.

There was no record of capacity assessments to support people to ensure their liberty was not restricted. We saw no record of best interest decisions.

Staff training was effective and people were happy as their staff teams received specific training on how to meet their individual needs.

Referrals were made to other healthcare professionals to ensure appropriate advice and guidance in relation to meeting peoples nutritional needs.

Is the service caring?

Good 

The service was caring.

People were very positive about the relationships they had with staff and described them as being caring, compassionate and respectful. One relative explained to us that staff couldn't do more if they were caring for their own relative.

People and their relatives were involved in developing care plans and specific communication plans were in place for people.

People told us their privacy and dignity was respected by staff.

Is the service responsive?

Good 

The service was not always responsive.

People's needs were assessed and reviewed and care plans were person centred but they did not always provide the detail staff needed in relation to the frequency of monitoring and checks of certain checks.

The registered manager explained the care plans were a "work in progress" and they would be reviewed for detail.

Summary of findings

Complaints were responded to in a timely manner and changes to practice were implemented in response to people's concerns.

Is the service well-led?

Good

The service was well led.

Staff felt well supported by the provider and told us management were approachable and available.

Internal audits and surveys were completed and the registered manager acknowledged that systems for communicating action and improvements could be improved upon.

L S Care Limited

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 21, 22, 28 and 29 September 2015 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be at the office to support the inspection.

The inspection was completed by one adult social care inspector and a specialist advisor.

Before the inspection we reviewed the information we held about the service. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally required to tell us about. The provider also completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service,

what the service does well and what improvements they plan to make.

We also contacted the local authority commissioners of the service and the safeguarding adults team.

We spent time at the office location and were supported by the registered manager during the inspection. We met and spoke with the two directors, an assistant manager and five health care assistants. We also contacted 13 staff by email and received four responses.

We reviewed seven people's care records including medicine records; staff files including competency, training and supervision. We viewed six staff recruitment records and viewed management records for the service.

We visited four people who use the service and spoke with three relatives about the service they receive.

Requires improvement

Is the service safe?

Our findings

One person's pain management care plan identified the medicine they were prescribed and how it should be administered but it was not included in the medicine list in the care record nor had it been included in the medicine care plan.

We saw one incident recorded where a registered nurse had administered crushed medicine to someone via a PEG tube because they had run out of their prescribed liquid medicine. This form of administration had not been prescribed by the doctor. This incident was appropriately investigated and action taken. We asked the registered manager about this. They said, "Crushing the tablets didn't alter the dosage but [person] isn't written up for crushed medicines." They also explained that it was the registered nurses responsibility to ensure medicines were ordered. This meant the ordering of medicine had not been kept up to date and the person had received medicines in a non-prescribed format.

We looked at medicine administration records (MARs) and saw 'lines' and 'crosses' on their MAR chart which did not correspond to any coding for the administration of medicines. The registered manager told us these were historic MAR charts and that they had introduced a new coding system for the charts. We viewed another person's MAR chart whilst visiting them at home and noted that staff had recorded an X against some medicine administration times. X was not an official coding on the MAR so we asked staff. They said, "It means [the person] didn't need the medicine, they are able to say if they need the medicine or not, so we record an X. We could do with updating the coding really so not needed is there." They added, "We would do a handover and explain about it in the daily notes." This coding was being used for medicine that was prescribed to be administered on a routine basis. This meant the person was not being administered routinely prescribed medicines as they decided they did not need the medicine. We did not see evidence that this had triggered a review of medicine with the prescribing doctor.

One person had a note on their MAR which stated, 'Change position on skin on each change of patch.' The notes on their daily notes recorded, 'Changed patch." However, we were unable to see a 'Transdermal Patch Application Record' to record the change of patch, together with the location. The registered manager showed us a blank 'Transdermal Patch Application Record' and reassured us it would be in use immediately for the person.

This was a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

We asked about medicines audits and the registered manager explained that they were currently completed as part of the overall care record audit. They added, "Starting next week we are going to do a separate medicines audit. This is in response to missed signatures for creams so the documentation has changed."

People had medicines care plans and risk assessments and as and when required medicines were included in the pain management section of care plans. Risk assessments included safety measures including adhering to medicine policies and procedures and recording information. Some people we visited managed their own medicines and this was reflected in care plans.

One relative said, "Medicines are managed safely and well. I'm always here if there's a problem and I keep an eye on things." Another relative said, "[Relative] is in good hands." Another said, "We feel safe with the staff, there's no issues."

Staff understood what to do if they felt someone was at risk of harm or abuse. One staff member said, "I'd phone the manager and speak to someone, normally the clinical manager of a package but I'd speak to someone and make sure it was passed on."

Where safeguarding concerns had been raised with the local authority they had been investigated and any necessary action was recorded. Some changes to practice had been introduced following a safeguarding raised in relation to poor recording of medicines, however we found further evidence of poor medicine recording as detailed above.

Risk assessments were in place for areas such as falls, moving and handling and pressure sores. Risks had been identified and actions recorded to reduce and minimise any harm to people and their staff. Standard supporting tools such as the Waterflow Pressure Ulcer Risk Assessment and Nutritional Risk Score tools were routinely used in the

Is the service safe?

completion of individual risk assessments. In addition risk assessments were in place for people who had complex medical needs, for example, oxygen use, the use of nasal suctioning and the use of catheters.

Risk assessments were regularly reviewed and any changes to people's assessed needs were added to their individual care plans.

Accidents and incidents were recorded and included any changes in people's behavioural presentation as well as falls and medicine errors. There was a full record of the actions taken to respond to and manage any incidents and accidents.

There were safe, robust mechanisms in place for staff recruitment. This included an assessment of staff knowledge, ability and experience, communication, personal qualities and motivation prior to being offered a post. Two references were sought and a disclosure and barring service check was completed prior to people commencing in post and at three yearly intervals. The service also completed monthly Nursing and Midwifery Council (NMC) checks of all nurses to ensure their registrations were up to date.

The registered manager explained they had introduced the 'Mums test' to their recruitment practice. We asked what this meant. They said, "Would I like to have this person look after my Mam. We have turned staff away because of it. We recently recruited eight staff and applied this and they have stayed with us beyond their training. We use scenarios based on 'if your Mam needed…. what would you do." They added, "Some people we support and their family are involved in recruitment of their staff. It worked well."

Staff told us there were times when they felt short of staff, but explained that people didn't want too many staff involved in their care so it was a constant balancing act. One staff member explained that they sometimes got calls to see if they would cover shifts after finishing a night shift and it would be better if the rota was checked to see what work people had done before they were called to cover additional care packages. An assistant manager said, "There are enough staff to meet people's needs, we are always recruiting as we want to grow."

One person said, "Yes, there's enough staff. It's a balance to cover the rota and make sure staff have frequent visits. My staff need specific skills so they need to keep the routine up. It's just about where we need to be." Another person told us, "I have my own team. I picked my own staff, I've been lucky so far." One relative said, "[Person] has regular carers, they don't settle well with strangers so they try to keep to a set of people who [person] knows and is used to." One relative said, "There's always one carer here, there's never a time when no one turns up."

Requires improvement

Is the service effective?

Our findings

The Supreme Court judgement made in 2014 extended the scope of Deprivation of Liberty Safeguards (DoLS). These safeguards are part of the Mental Capacity Act 2005 and are a legal process that is followed to ensure people are looked after in a way that does not inappropriately restrict their freedom. If a person is receiving care in a community based environment, arranged by the local authority, the Court of Protection must authorise any deprivation of liberty. This is the only route available. Anyone who feels that a deprivation of liberty in this setting may be required can ask the local authority to seek authorisation.

Five people's consent to care and treatment records were signed by people's relatives however we saw no evidence that assessments had been completed of people's capacity to make particular decisions, nor did we see records relating to best interest decisions where people lacked the capacity to make certain decisions themselves. Risk assessments in relation to the use of bedrails were in place and regularly reviewed but there was no record of the person's capacity to consent or that the bed rails were being used in the person's best interest. Although it is recognised the bed rails are to protect people, people should still be involved in the decision making if they have capacity or it should clearly be recorded via a best interest meeting if the person lacks capacity. Bed rails are not a form of restraint if used to protect patients from accidentally falling out of bed, or if used for immobile patients. However without assessing people's capacity to consent people's rights to make particular decisions may not have been protected.

Records did not provide evidence that assessments had been completed to check whether the plan of care would amount to a deprivation of the person's liberty. One person did have a capacity assessment which had been completed in 2010 with the outcome that they did not have the capacity to manage their own finances but they were able to make day to day decisions regarding their care and treatment. The assessor had noted that life changing decisions and any decision of complexity would need to result in a further mental capacity assessment specific to the scenario it related to.

The registered manager said, "We should focus more on best interest decisions and mental capacity in the care plans."

The registered manager told us that one person's relative held a lasting power of attorney for health and welfare. This meant the relative had been given the right, by a court, to make best interest decisions on the person's behalf as they lacked the capacity to make the decisions themselves. There was no evidence of this in the persons care records which meant staff may have been unaware that the relative had this power.

This was a breach of Regulation 11 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The assistant manager said, "I'm mental capacity and DoLS trained. If I thought someone lacked capacity I'd contact the social worker or the duty team and ask them to look at doing a capacity assessment. I'd report any concerns, contact the GP for advice and support as it might be due to an infection. It would also trigger a review of the care plan and risk assessment."

Staff told us mental capacity act training was available but some staff said they hadn't attended the training. One staff member said, "We don't assume capacity is lacking and we don't make decisions on behalf of people. I haven't done the training but it's covered in safeguarding as well."

Another staff member said, "We do work with people who lack capacity. We use boards and pictures with someone, it's what they are used to, it's in the care plan and it means they can tell us what they want." Another staff member said, "Relatives are with us in packages so they know more about it. We do things like showing two things to offer a choice to people." Staff told us they had not seen any information on mental capacity or lasting power of attorney in people's care records, one staff member said, "Care is provided into a family home so there's generally someone else there, a relative, so we don't see the information."

The registered manager told us, "Initial induction training was two days looking at policy and procedures and documentation, three days are spent doing moving and handling, health and safety and food hygiene. Staff are introduced to clients with the manager or another carer." They added, "Depending on the persons needs shadowing would happen for one to three days. It would depend on the confidence and competence of the staff." Senior staff had completed training in the Care Certificate and this was being rolled out for all staff who were new to health and social care as part of their induction.

Requires improvement

Is the service effective?

Staff said, "We do mandatory training annually, if there's new equipment we are trained quickly or if its complex care the hospital have trained us or physios or nurses." They added, "I've done a diploma in end of life care; safeguarding annually." Another staff member said, "We can ask if we need extra training or if we don't feel we are meeting people's needs. We can also put it in appraisal [supervision] so there's a record."

We asked staff about the competency's needed to support people with complex health needs. One staff member said, "They do match your skills with people; they wouldn't put you in a situation that you aren't trained for." They added, "We have shadowing if we join a new package." Another staff member said, "We do group learning, you get a competency form for each package and you are ticked off as competent to work in that package. If you aren't competent they won't sign you off." They added, "One of the clinical nurses do the competency at each package. We only deliver the care after we've been assessed as competent so if there's any changes we are re-assessed." They went on to say, "Because we are assessed with each client it also acts as a refresher."

"Sometimes we are on shift with nurses, or the district nurse, physio, home vent team or the RVI (Royal Victoria Infirmary) also do training."

One person said, "Everyone who comes is specifically trained for me." "Confident carers [staff] show new staff what to do." Another person said, "Staff do shadow shifts until they are confident. I'm really well looked after." "Staff are trained by the ventilation team."

We saw a record of staff competencies which were linked to the specific needs of the people they were supporting. Examples included basic care, supra pubic catheter, PEG care, devil bliss suction, cough assist, naso-pharyngeal suction, suppositories. This meant staff had been supported to develop their skills and understanding in supporting each person. The registered manager told us that staff competencies were checked at the onset of each person's package of care by the clinical manager and thereafter whenever aspects of the care changed.

The registered manager explained that consultation forms for training had been introduced as staff feedback had shown that some training was becoming mundane as they completed it annually. This meant staff were consulted on what they needed from training so it was tailored to what they wanted and needed. Training refreshers had become more discussion based so learning came from people's experiences. The registered manager said they had received feedback that staff felt more able to do their job after training was delivered in this way.

Staff told us they received supervision every three months and an annual appraisal. One staff member said, "It's done by any of the managers involved in the package, some assistant managers also do them." Staff said they felt well supported with personal issues and one person said, "They [managers] were there when I needed their help."

A recognised nutritional risk screening tool was used on a monthly basis to identify if people were at risk of malnutrition. Where people had been identified as at risk referrals had made to dietitians for specialist advice. People had also been referred to speech and language therapy (SALT). We saw one person needed thickened fluids but this had not been transferred to their nutrition care plan.

Food, fluid and weights charts were in place and intake was monitored closely and charts were completed as directed in care plans. If someone's weight was fluctuating this triggered referral to the doctor or dietitian for additional support and advice. Some people were not able to be weighed at home but we saw this was completed when they attended their dietitian appointments.

Staff worked with various health care agencies and sought professional advice if people's needs changed. This included accessing district nurse teams, tissue viability nurses, neurology teams and occupational therapy. This meant the expertise of appropriate professional colleagues was available to ensure people's health and well-being was met.

One relative said, "The staff recently told me [person] might have an infection, and they were happy to speak to the doctor about it. If they are worried they inform the doctor or ring the district nurse if there are any issues and things get resolved."

Good

Is the service caring?

Our findings

People were complimentary about the care they received. One person said, "Staff are caring and gentle. They do respect me." They added, "I was involved in my care plan. If I wanted it re-worded or changed I just let them know. If they note a red mark or anything it's all passed on by the staff and recorded. Staff have signed to say they've read it and understood it [the care plan]."

Another person told us, "I have no problem with the staff on my package. It can be difficult if people leave as you become friends with people and then you need to start again with new people." They added, "I can't fault it."

Staff said, "Generally we have the same case load. It might alter for emergencies or staff cover. It helps with relationships and providing care if we work with the same people." We asked how new staff were introduced into people's care packages. Staff said, "Experienced staff would work alongside someone else initially." They added, "If it's a new person the care plan would be in place usually and the manager would go along with us to do introductions,"

One relative said, "Staff are really caring and professional, they couldn't do more if it was a member of their own family." They went on to say, "They are respectful, caring and compassionate." Another relative said, "They always explain what they are doing and why; even to putting [persons] glasses on." When asked about the care plans they told us, "We are involved in reviews when care plans are updated. The managers come down and we discuss any changes. Any new procedures and we are involved." They added, "There's good communication, if they are stuck in traffic or going to be late they always let me know."

One relative said, "There's no problems at all with privacy and dignity, they are caring and gentle, they have a good laugh together, they have good relationships."

Staff were aware of maintaining people's dignity during personal care and one staff member said, "We give people the choice of having a male or female carer where we can." They added, "I would never discuss clients with any inappropriate or irrelevant person." Another staff member told us, "Services provided are personalised as much as possible, ensuring privacy for intimate care and treated with respect at all times." Another staff member said, "I always listen, I give my clients the space that they need, offer them choice and ask them what they want."

One care manager said, "My personal observations have noted that staff are openly kind, treat those in their care with dignity and respect and are compassionate and sensitive in their practices with patients."

Communication care plans were in place and we saw specific detail for staff to follow in relation to how they engaged with people. One person's communication plan stated, "Ensure direct contact is made when communicating with [Person], ensure [Person] and family are kept informed of all procedures to avoid periods of stress. At times [Person] may have periods when they want to be quiet and stay in their bed listening to music, carers need to be aware of this and act accordingly."

Another person's stated that they could verbalise and communicate their needs well. It went on to direct staff to, 'Ensure direct eye contact is made when communicating with [Person] where possible, lower yourself to [Person]'s level, understands everything." The individual approach to meeting peoples needs meant staff provided flexible and responsive care, recognising that people living with communication needs could still happy and active lives.

We saw that people and their relatives were involved in care planning and the care plan documentation was often signed by a family member. There was no indication as to why some people hadn't signed their care plans but there was clear evidence that people were consulted about their care, and thus the quality and continuity of care was maintained.

People told us they were able to advocate for themselves and were needed people had family members or staff who acted as their advocate. Relatives told us that they were aware of advocacy services if they were needed.

Good

Is the service responsive?

Our findings

One person said, "I have a lead role in my care and support. The Care plans were written with my input. There's no issue as I know what I need. I understand my condition from a clinical view so I can say what I need. My needs are catered for well."

One relative said, "They involve [person] and us in decision making, they speak to [person] about the care being provided, they are really good."

Records showed that people had their needs assessed before they started using the service. This ensured the service was able to meet the needs of people they were planning to admit to the service.

People's care records were personalised to reflect their individual preferences, support and what they could manage for themselves. The care planning system was simple and easy to follow, with risk assessments and regular evaluations. We also saw information about people's life history and interests.

We found that some care plans referenced that staff should make 'reasonable checks' on things such as people spending time alone, personal care or skin integrity. This meant there was no specific guidance for staff on when to complete the checks. The registered manager acknowledged they had re-written care records from May 2015 and told us, "It is work in progress." They offered reassurance that documents would be reviewed to ensure consistent specific information was recorded in relation to the frequency of making checks.

Care plans included a dependency needs score which was reviewed every month. This meant there was a summary of the care people needed which could be cross referenced to staff competency to ensure they had the skills needed to provide appropriate care for people.

People's needs were clearly identified and specific plans for supporting people with their mobility needs were in place and regularly reviewed. One person's mobility plan stated, 'Requires two staff for all aspects of moving and handling.' Others had personal information on their likes such as, 'During the day I like to be upright in my wheelchair or cosy chair and I sometimes like a pillow.'

This meant records described the care staff needed to provide.

Care plans in relation to pressure care were up to date but were of variable quality. Re-positioning charts and body maps were maintained and completed as directed in care plans. Care plans detailed that staff should, 'Observe pressure areas regularly' however there was no record of what 'regular observation' meant so staff may be interpreting this very differently so people may not have been receiving consistent observations. Other care plans were individualised and stated, 'Ensure no creases in [Person]'s clothes and bed sheets, contact tissue viability nurse to seek additional advice at least every 3 months for review or in the event of changes to X's pressure areas; tissue viability nurse is available for advice as required and will visit in the home.' However, we were unable to see any record of the person's review with the Tissue Viability Nurse for this person.

One person's care plan stated, "I have had pressure damage in the past and need regular pressure area care to ensure this doesn't happen again. I have a dressing on my [Area], this is changed every three days unless it comes off then will be changed as required.' Another person's recorded that regular positional changes were needed and that specialist pressure relieving equipment was in place but it did not detail what this equipment was or how it should be used. This meant people's care plans did not always contain sufficient detail to instruct staff what action they should take to maintain skin integrity.

Continence assessments were completed and care plans detailed the recommended products that people should use but some entries included 'regular checks' with no specific detail on how often this should be completed. The registered manager offered reassurances that care plans would be reviewed to ensure specifics were included.

Care plans were reviewed monthly or more frequently if there were changes in people's needs. These changes were signed by a senior nurse assessor and reviews resulted in the development of new or review of care plans. Staff said, "We can say if a care plan isn't right or if there are changes, mostly comments are listened to on the whole." The assistant manager said, "I've been trained in writing care plans, they are reviewed monthly. I'm also risk assessment trained. We all did IOSH training which was helpful for risk assessments." IOSH is the Institution of Occupational Safety and Health.

One person said, "Reviews happen once a month, if there's something urgent they happen more often." A care

Good

Is the service responsive?

manager said, “Such is the complexity of patients that there is an expectation that the service will adapt and change to patients presenting needs, LS Care do so admirably ensuring that the multi disciplines are advised of changes, weekly emails assist me as a case manager understanding every changing presentation of patients (both deterioration and progression).”

We found that were complaints had been received they were fully investigated and changes to practice were made as needed. Complainants had been kept up to date with the progress of the investigation and apologies had been offered where necessary. One relative said, “There’s nothing that could be done better.”

One person said, “There was some inconsistency in the staff team in terms of staff being pulled out to go somewhere else and sometimes staff were put in who couldn’t clear my chest and I need staff who are trained as I can aspirate [choke]. Now no one comes unless they are with one of my own trained staff. All my staff are trained.” They added, “I did put a complaint in and I got an apology and it was investigated. I got a letter with the outcome on and we agreed staff would have one month’s shadowing before they were put on my rota.” They added, “I am happy with how they dealt with it and they also apologised for the time it took to deal with it.”

One person said, “I think it’s well managed, there are no issues, it’s a two way street if there are issues I contact them straight away. They seem to have a common sense approach. The one major issue was dealt with to my satisfaction. To their credit they dealt with it and made me aware of the outcome.” “There are no improvements. For the most part it’s good – solid. We have good relationships.”

A relative said, “I’ve no concerns or complaints, if I did have I’d speak to the supervisor.” Another relative said, “I know how to complain, I would contact the office.” One person said, “I’m happy for the most part, there was a misunderstanding but it got addressed.” Another person said, “Sometimes the rota and hours can be an issue as some staff do a call before or after a night shift and I need staff to be alert to care for me. I think sometimes staff can be put on a bit too much.” They added, “It’s either a famine or feast for staff for the hours they get to work.”

Good

Is the service well-led?

Our findings

One staff member said, "[Registered manager] is absolutely supportive, she's excellent." They added, "The directors are approachable." Another staff member said, "It's the best company I've ever worked for, approachable and supportive, you are rewarded for good work, appreciated. We get thanked for doing a good job, I feel valued."

Another said, "It's a brilliant company. We provide a high level of care. The company was started to support people with complex care needs and nothing could be done better. I'm an extremely happy employee, very well looked after, trainings offered and competencies are updated. We are doing really good work!"

The registered manager said, "I started as a Health care assistant and became operations manager, the support has been fabulous. My knowledge has increased, the transition was good. Staff are treated fairly, we work with people and staff to meet their needs. Continuity is there and people have a core team of staff."

Management meetings where held weekly and attended by assistant managers, the registered managers and directors. During these meetings each person was discussed in relation to a review of care and any actions that needed to be taken.

We asked the registered manager about team meetings. They said, "One person has regular team meetings held in their house." They added, "We have a weekly clinic where staff can drop in but staff aren't using it at present, so we are going to reintroduce it and put it into the newsletter. We would keep an attendance record." They added, "If there was a specific issue we would hold a meeting and there's 24 hour access to on call."

We asked an assistant manager how they communicated with their staff teams. They said, "We use the communications book and have email contact with people. Obviously they have supervision and appraisal. We also have phone contact with people, especially for anything urgent." They added, "The complex packages have set teams so it's easier to communicate." The assistant manager acted as the link person for communicating information to and from the management meetings for staff.

We asked how staff were involved in the development of the service. The registered manager said, "We listen to staff, send them questionnaires, we have an open door policy, staff aren't penalised for anything they say, we use constructive criticism. We want to keep good staff and we invest in them, we have longevity in our staff. We help if they have a problem. They can come in anytime." We saw that questionnaires were also sent to people who used the service.

People were sent questionnaires twice a year and were asked what they liked best about the service and what could be improved. People commented, 'Excellent standard of care, treated with care compassion and dignity,' and 'I have settled regular staff with no changes.' People had provided feedback that they didn't always feel included in L S Care Limited as a company. In response the registered manager explained that they were introducing an annual newsletter at Christmas time. They added that some of the people they support had also met each other using social media and were using this to gain support on their specific health conditions.

Staff questionnaire were sent out every six months. We saw that the questionnaires were analysed in monthly quality meetings. At a meeting in March 2015 it was recorded, 'Questionnaires have been analysed. Poor response from both clients and staff. No negative feedback.' In the July meeting it was recorded, 'Staff questionnaires not due to be analysed until September's meeting but suggested a senior manager does yearly appraisal as they would make staff feel more valued. This will be put into practice with immediate effect and incorporated into policy at the next review.' There was no system in place for letting staff and people using the service know the results of questionnaires and what actions the provider was taking in response to their feedback. It was therefore difficult to assess where improvements to quality had been made as a result of feedback from people and staff. We asked the registered manager about this who said, "We could tighten up on things and do more of a 360 trail." They added, "We could add the information into the newsletter so everyone can see it."

Internal quality audits were completed, with the last one being dated July 2015. The audit looked at care plans, medicines, feedback from people using the service, complaints and compliments, communication and health and safety. The audit summary report highlighted any

Good

Is the service well-led?

concerns and identified the action that needed to be taken but there was no timeframe or responsible person identified, nor was there corresponding information on the audit to assess whether the action had been completed or not. We asked the registered manager about the audit process. They said, "Internal quality audits are completed three monthly, we discuss them in quality meetings and action plan with a deadline and a named person. This is then followed up on the next quality audit to see if it's been actioned."

We asked people and relatives about how the service they received was monitored. One relative said, "The assistant manager visits, they are lovely, really helpful and good." They added, "There's no improvements, we are quite happy with them, they are ok, no real problems at all." One person said, "I monitor if things are going right and let care managers know. I send an email to the office if things aren't right and they sort it." They added, "The managers used to visit regularly. [The registered manager] will ring and pop in, they keep an eye on me from a distance, it's in my care plan that they visit by appointment only."

An assistant manager said, "I work with clients and have office weeks so I do a bit of everything. I do rotas, shift cover, admin, supervision, training needs and requirements." They added that this way of working meant they could directly deliver care, observe care staff and keep in touch with people about the care they received. They also explained that it gave them the opportunity to speak to people receiving the service and ensure they were happy.

The registered manager told us that daily notes were used for the staff handover which showed that people's needs, daily care, treatment and professional interventions were communicated when staff changed duty, at the beginning and end of each shift.

Quality meetings were held on a monthly basis which included accidents and incidents, complaints and compliments, health and safety, staffing and training. An analysis had been completed of recent audits of care records. Reviews of care records were going to be arranged to managers who were not involved in that particular care record reviewed it to assess the quality and completeness of information.

A summer newsletter had been sent to employees which congratulated staff on personal events in their lives such as engagements and weddings; there was also an acknowledgement for the employee of the month and a reminder about the completion of timesheets.

The registered manager advised that they kept up to date with best practice by attending a variety of forums wherever possible.

This section is primarily information for the provider

Action we have told the provider to take

The table below shows where legal requirements 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 did not take formal enforcement action at this stage. We will check that this action is taken by the provider.

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment **The provider did not ensure the proper and safe management of medicines. They did not ensure prescribed medicines were available at all times. Regulation 12(2)(f) and 12(2)(g).**

Regulated activity	Regulation
Diagnostic and screening procedures Personal care Treatment of disease, disorder or injury	Regulation 11 HSCA (RA) Regulations 2014 Need for consent **The provider was not acting in accordance with the Mental Capacity Act (2005) Code of Practice. Regulation 11.**