Accord Housing Association Limited

Direct Health (Nottingham City)

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?	Requires Improvement
Is the service well-led?	Requires Improvement

Summary of findings

Overall summary

We carried out an announced inspection of the service on 14 and 15 May 2018. This was the provider's first inspection from the date of registration in 2017.

This service is a domiciliary care agency. It provides personal care to people living in their own homes within and around Nottingham City. It provides a service to older adults and younger adults living with a range of health conditions and needs, to live independently in the community. Not everyone using Direct Health (Nottingham City) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

At the time of our inspection, 325 people were receiving personal care as part of their care package.

There was a registered manager at the service. 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.

Risks associated with people's needs had not been consistently assessed and planned for. Some risk assessments used to instruct staff of action required to manage risks, were insufficiently detailed or not completed.

Shortfalls were identified in the management of medicines; best practice guidance was not always followed.

Accidents and incidents were recorded but there was an inconsistency in how one incident had been responded to. Incidents were reviewed to consider if there were any lessons that could be learnt.

There were sufficient staff to meet people's needs. New staff were constantly being recruited due to the size of the service. Staff's availability to pick up new care packages was considered. Safe staff recruitment checks were in place and followed.

Staff had received training in infection control and food hygiene. Staff followed best practice guidance in the management of risks associated with infection and cross contamination.

Staff received an induction and ongoing training, but shortfalls were identified in the ongoing support provided to staff.

People's nutritional needs had been assessed, but these needs were not always sufficiently supported and effectively managed.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. However, staff had limited knowledge of how to respond if people no longer had capacity to make some specific decisions. Some mental capacity assessments and best interest decisions had been made, but these had not always been consistently completed.

People's healthcare needs were monitored and action was taken when changes occurred such as informing the person's relatives and representatives or health and social care professionals.

Staff treated people with respect and kindness, they were caring and compassionate in their care and approach. Independence was promoted and privacy and dignity respected. People had access to information about independent advocacy services.

There were plans in place, which detailed people's care and support needs but these lacked detail in places and had not always been updated when required.

People knew how to raise a concern or make a complaint and the provider had implemented effective systems to manage any complaints that they received.

People received opportunities to share their feedback about the service. The provider and registered manager had met their registration regulatory requirements.

The provider had systems and processes in place to regularly review the quality and safety but these had not always been effectively managed. The provider's internal auditor found shortfalls in April 2018 as identified in this inspection. At the time of the inspection, an action plan was already in place to address these issues and progress was being made.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Risks associated with people's needs had not always been sufficiently assessed and planned for.

Shortfalls were identified in the management and support of people's medicines.

There was a concern identified in relation to how an incident had been responded to.

Staff were aware of how to protect people from abuse and avoidable harm.

Staff followed infection control measures to prevent the risk of cross contamination.

Is the service effective?

Requires Improvement

The service was not consistently effective.

The support available for staff was variable and inconsistent.

People did not always receive effective support with meeting nutritional needs.

The principles of the Mental Capacity Act (2005) was not fully understood by staff or consistently adhered to.

People's health was monitored and changes were shared with others where required.

The assessment process considered people's diverse needs to ensure there was no discrimination in relation to the protected characteristics under the Equality Act.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and compassionate.

People had information about independent advocacy services should they have required this support.

People were involved in their care and support.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

Care plans lacked detail in places and had not been updated when changes occurred.

People's communication and sensory needs had been assessed. Some consideration to how information was provided to people had been made.

People had access to the provider's complaint procedure and action had been taken to written complaints received.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

The provider had systems and processes in place that had not been effectively used to check on quality and safety. The provider had identified this and an action plan was in place to drive forward improvements.

People were provided with opportunities to feedback their views on the service, although this had not been developed to ensure it was in an accessible format.

There was some partnership working to ensure people received care and support that met their needs.

Direct Health (Nottingham City)

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 checked 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 comprehensive inspection took place on the 14 and 15 May 2018 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 the registered provider and their staff would be available.

The inspection team consisted of two inspectors and four Expert-by-Experiences. This is a person who has had personal experience of using or caring for someone who uses this type of care service.

As part of the inspection process, we sent questionnaires to 50 people who used the service and received 17 responses. We sent 50 questionnaires to relatives of people using the service and received nine responses, and we sent nine questionnaires to external professionals and received one response. In addition, we attempted to contact 100 people via telephone to gain feedback about their experience about the service. We spoke with 42 people who used the service and 15 relatives. We also received feedback from a further external professional.

Before the inspection, we asked the provider to send us their Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. We reviewed this and other information that we held about the service to help plan the inspection such as notifications. These are events that happen in the service that the provider is required to tell us about.

At the provider's office we spoke with the registered manager, care service director, quality manager,

training manager, chief executive, two care coordinators, three senior care staff and six care staff. We reviewed the care records for 13 people who used the service. We also looked at a range of other records relating to the running of the service such as policies and procedures, complaints, six staff files and the staff training plan.

Requires Improvement

Is the service safe?

Our findings

People who used the service told us staff supported them with any known risks to remain as safe as possible. This included how risks were managed in relation to personal safety within the person's home. A person who used the service said, "They (staff) help me walk around and make sure I don't fall." People told us of the action taken by staff when entering and leaving their house to protect their safety and how security was managed. Staff wore uniforms and ID badges to confirm their identity.

Most staff told us that information and instructions of how to support people with known risks, was frequently out of date or lacked specific detail. Staff also told us they received information via work mobile telephones to inform them of any changes with people's needs. Some staff told us this information was sufficiently detailed, whilst others felt it lacked information about people's current needs. Staff also told us any concerns about risks that they identified were shared with the office team. Action was then taken such as contacting people's relatives and external health and social care professionals. Staff told us of the procedures they followed if a person was not available when they visited. This meant checks were taken to ensure people's safety and well-being.

People's care records confirmed their health and welfare needs had been discussed with them and or their relative/representative. An assessment of the internal environment had been completed for the safety of the person and the staff supporting them. However, there were inconsistencies in how risks were assessed and how staff were instructed on how to manage these risks. For example, we saw a care plan for a person with diabetes did not include the signs and symptoms of hypoglycaemia (low blood sugar) or the action staff should take if the person was not eating. However, another person with the same condition had a risk assessment completed with these details. We saw examples where people were living with health conditions such as asthma, arthritis, high blood pressure and progressive illnesses, had not always had their needs and any associated risks assessed. This meant staff had insufficient information of the risks and actions required to maintain their health and safety. The management team told us they were aware of some shortfalls and had a plan in place to review people's care records to ensure staff had up to date and detailed information.

Some people required support from staff with the administration of their medicines; this was either assistance or a prompt. A person told us, "I take my own (medicines) but they (staff) always check I have taken them." Another person said, "Yes, they give me my tablets, there is never a problem with that." However, some people raised concerns that if their call times varied, this impacted on when they received their medicines and this was a concern to them.

We noted from people's care records where they had medicines that were time critical (they required their medicines at a specific time), this was flagged up on the electronic system used to monitor and manage people's care packages. An alert was also made in the person's care plan and in addition, shared with staff via their work mobile. From the sample of peoples' daily logs we reviewed, we noted people overall had received calls to support with medicines at the time required.

Staff did not always follow the provider's medicines management policy and the policy was not supported by national best practice guidance. Concerns were identified in the management and monitoring system in place to ensure people received safe and effective support with their medicines. Medicine administration records (MAR) showed staff had recorded people's prescribed medicines, but there was no second staff signature to confirm the transcribing had been completed accurately. This is good practice guidance.

There were numerous gaps on the MARs indicating either medicines had not been given or the member of staff had not signed the MAR. The management team told us they cross checked against the daily log and if staff had recorded they had given medicines, they took this to mean the person had been supported with their medicines. There were no checks to ensure this was correct. Where people had medicines prescribed as and when required (PRN), there was no protocol in place to inform staff how this medicine should be administered. This is important information to ensure these medicines are managed and administered safely and consistently.

Staff told us they had received training in the administration of medicines and that they had a competency observational assessment. Records confirmed what we were told and also of the action taken in response to medicine errors, this included staff receiving additional training or disciplinary action was taken. The management team told us how they were working with an external healthcare professional, to make improvements to the management of medicines.

There were sufficient staff to meet people's needs. Staff told us due to the size of the service staff were constantly being recruited to ensure it could continually meet any new care packages. Staff also told us that overall, they provided regular care for people but could be asked to provide additional support to cover staff shortfalls. A care coordinator told us that they always considered staff availability before agreeing to new care packages.

The provider had safe staff recruitment checks in place, to mitigate against the risk of employing unsuitable staff. This included checks on staff identity, employment history and criminal records. References were also requested prior to employment.

The provider had a system to record and monitor any accidents or incidents however, we were concerned incidents were not always investigated as required. For example, a staff member gave an example of an incident, which had occurred the previous weekend in relation to a particular medicine. They said they had reported it to their care coordinator. Whilst the care coordinator had been informed of the incident, they had not completed a detailed investigation and did this after we requested this. The registered manager told us how they reviewed and monitored accident and incident records for any lessons learnt. They said where improvements were identified in the delivery of care and support; this was shared with staff by way of memos or text messages to staffs work mobile. We saw examples when information had been shared with staff as described to us.

People who used the service told us they felt staff supported them from the risk of abuse and avoidable harm. One person said, "I have always felt safe with all of them (staff)." 94% of people who responded to our questionnaire reported they felt safe from abuse and or harm from staff.

Staff demonstrated an awareness of the different categories of abuse and what action they would take if they suspected a person was experiencing any form of abuse. A staff member gave an example of the action they had taken in reporting concerns and how this had resulted in a safeguarding investigation by the local authority. Where safeguarding concerns had been identified, we were aware the registered manager had taken correct action such reporting this to the local authority safeguarding team. This had also included

taking staff disciplinary action.

Infection control measures were used by staff to mitigate against the risk of cross contamination. People who used the service told us staff wore single use gloves and aprons and staff confirmed they had an ample supply of personal protective equipment. Staff told us they had completed infection control and food hygiene training and staff training records confirmed this.

Requires Improvement

Is the service effective?

Our findings

People who used the service were positive staff had the required skills to give good care and support. Positive feedback was received from our questionnaire and from people we spoke with. A person said, "I believe they (staff) are well trained, all are very professional and they seem well supported." Another person said, "The staff seem to know a fair amount, medically."

Staff received an induction on commencement of their employment, this included a period of shadowing experienced staff and they received ongoing training and support. Staff were positive that the induction supported them to understand their responsibilities effectively. One staff member said, "The induction was helpful. I learnt what is expected of me."

Staff records showed staff were required to complete Care Certificate training. The Care Certificate is a national set of standards that health and social care workers are expected to adhere to. Staff told us about the ongoing training the provider had identified they were required to complete, such as health and safety, move and assist, basic life support and fluids and nutrition.

Staff received opportunities to discuss their work and review their training and development needs. The provider had identified staff required a one to one meeting every six months. With new staff they received a meeting at three months. In addition, a spot check on staff performance was required.
However, from speaking with staff and reviewing staff records, we found there were shortfalls in the frequency and inconsistencies in this support. For example, two staff told us about their last spot check, the assessor had arrived at the person's home after they had completed most of the care including assistance with the person's medicines. This meant this was an incomplete observation. One staff member told us they had had worked for 17 months and had their first spot check the week before our inspection and no other supervision or appraisal. Whilst another staff member had worked at the service for five months and had had two spot checks. A third staff member told us they had never had a spot check in over five years with the service.

The registered manager told us they were aware that the frequency of spot checks needed to improve and advised us 71 staff spot checks had been completed since January 2018. However, we concluded that the support provided to staff was variable and this was a concern due to staff lone working and the level of responsibility they had. We discussed this with the care service director who agreed to review the support provided to staff.

Some people required assistance with their meals and were positive that staff were supportive and ensured they had drinks, snacks and meals provided where required. One person said, "My carers always make sure that I have a nice hot drink as soon as they come through the door and usually make me another before they go. They insist I have some biscuits or something so if I get peckish I can help myself instead of struggling into the kitchen."

Whilst staff told us they supported people with drinks and meals where required, we identified some concerns in the support provided. For example, some people had been identified by commissioners (local authority who fund some people's care package) at being at risk of malnutrition. This was due to them not eating regularly or sufficiently and this was one of the reasons the care package was commenced. However, two people's care plans did not reference this. There was no clear reference to the amount the person was eating or that staff checked the person had consumed the food prepared. A care plan review document for another person stated their relative was concerned they were not eating; care staff were to remind the person to eat. However, staff did not record details of reminders or food eaten in the person's log book.

The service sometimes provided joint care packages with another provider and speaking with a care coordinator, it was apparent there was no system to share information across agencies. Some people were supported by community healthcare teams to help manage their health care needs. However, when staff needed to work alongside the community nurse and the timing of these visits were important, the care plan did not reflect this and how staff should work with the community nurse. The provider had implemented an information document for the use of ambulance crews should a person be admitted to hospital. This was to assist in the person's ongoing care.

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.

Staff had received training on MCA but were found to have a limited understanding of the principles of MCA. Staff said that the people they supported had mental capacity to consent to their care and support.

People's care records demonstrated people's mental capacity to consent to their care and support, had been considered at the point of assessment. However, when people lacked mental capacity to consent to their care, records reviewed found there were inconsistencies in the completion of assessments and best interest decisions. For example, decisions should be specific but it was not always clear from the assessment what decision the person was being assessed for. One person had an assessment completed that stated the person's family had been involved, but there was no best interest decision recorded. From another person's care records it was clear that the MCA should have been considered, as information indicated the person may not have had the mental capacity to consent to their care and support.

The registered manager was aware of their responsibility of reporting to the local authority, any person who lacked capacity who had restrictions of their freedom and liberty. In this situation, an application was required to the court of protection.

People received an assessment of their needs before they received a care package to support staff to understand and be informed, of what support people required. The assessment considered people's diverse needs to ensure there was no discrimination in relation to the protected characteristics under the Equality Act such as their age, disability, gender reassignment, race, religion or belief. Feedback we received from people who used the service did not raise any issues or concerns about experiencing any discrimination.

People who used the service retained responsibility for accessing health services but felt if they needed support, staff would provide this.

Staff gave examples of the action they had taken if they found a person was unwell; this included calling

relatives or paramedics for assistance. Concerns were also reported to care coordinators based in the office, who alerted health and social care professionals of any concerns or changes in a person's health that required action being taken.

Good

Is the service caring?

Our findings

We received positive feedback from people about the approach of staff. From the response to our questionnaire asking people if they were always introduced to care staff before they provided care or support, 88% of people said they were. Feedback from people we spoke with was also positive. A person said, "New members of staff come with my usual girls (staff) and they receive on the job training to use the hoist a few times and then they come as my working carer." Another person said, "I have had a lot of different staff to be honest, but they do let the new ones come with the old ones first." An exception to this was one person who told us, "I can tell when the agency is struggling a bit because I will open my door to find a brand new carer who I've never met before." This person went on to say, "When they are not so stretched, any new carer will come along with one of my regular carers, they can see exactly what I need help with."

An external professional gave positive feedback about the approach of staff. They said, "I have always found the care staff to be very professional and often go above and beyond when caring for a person."

We received a mixed response from staff about being introduced to people before they provided care. Whilst some staff said they had no one accompany them, others told us they shadowed other staff known to the person before they provided the person's care.

From the response to our questionnaire asking people, if staff were caring and kind we received 100% positive feedback. People we spoke with were equally very positive and complimentary about the staff that supported them. One person said, "We have been really fortunate, as we have a small number of lovely carers who will absolutely go out their way to do anything that it takes to make sure that [relation] is happy and content, it even goes as far as to sing along with them." Another person said, "The staff are wonderful, nothing is too much trouble and they always ask me if I'm ok and need anything else before they go." A third person said, "All the carers are very caring, they all go the extra mile for me." An example of this was that a staff member who attended the same church of a person, took them to church each week and returned them afterwards, this was in the staff member's own time.

From talking with staff they showed a real interest and caring and compassionate approach towards the people they supported. One staff member said, "I feel we have the right amount of time to deliver good care, we have time to chat to people and this is so important as we may be the only people they see all day." Another staff member said, "I enjoy every day of my work, I try my best to make sure people are happy with the support I give."

From the response to our questionnaire asking people if they were involved in decision-making about their care and support, 82% of people reported they were. Additionally, people we spoke with told us they were involved in their care. This was by staff promoting choices in people's everyday care, to people being involved in opportunities to discuss and review their care package. We saw examples of review meeting records that confirmed people's involvement.

Information had been made available for people about how they could access and receive support from an independent advocate to make decisions where needed. Advocates support and represent people who do not have family or friends to advocate for them, at times when important decisions are being made about their health or social care.

From the response to our questionnaire asking people if staff always treated them with respect and dignity, 94% of people replied that staff did. People we spoke with were also positive with one person saying, "The staff definitely respect my dignity, I feel very comfortable with them, they are very respectful." Another person said, "I feel okay with them when they help me have a wash, they put me at my ease." People also told us they were supported to be independent and to remain in their own homes.

Staff said they protected people's privacy and dignity by closing doors and curtains and covering people as much as possible during personal care. Examples included encouraging people with their independence. One staff member said, "It's important to support people to maintain as much as they can do for themselves." A relative told us, "I can often hear the girls (staff) asking [relation] to wash their face, this is really encouraging and another thing they are never rushed."

During the assessment and review of people's care packages, consideration was given about people's preferences in how they wished to be supported. The provider had equality and diversity policy and staff told us the care, and support they provided, was tailored to meet people's individual needs.

Information about people was kept securely in the office. The registered manager ensured that confidential paperwork was regularly collected from people's homes and stored securely at the registered office.

Requires Improvement

Is the service responsive?

Our findings

Prior to people using the service, an assessment was carried out to ensure their needs could be met by staff. People told us they had contributed to the planning of their care and support. Care plans were developed to inform staff of what people's routines, preferences and wishes were.

People who used the service were positive that staff understood their needs and provided support in the way they wished. Positive feedback was received from an external professional about how the service was responsive to people's needs. Comments included, "They (service) never hesitate to bring concerns swiftly to our attention and are always willing to put in urgent increases immediately (providing additional care), even if this means disrupting all the planning that's already been made."

Staff told us peoples care plans were not always updated to reflect people's current needs. A care coordinator told us they reviewed people's care plans yearly but this was more frequent if people's needs changed. The registered manager told us people should receive a review at six weeks from using the service but advised that this was not currently happening.

We found people's care plans had not been updated when changes had occurred as explained to us by the care coordinator. For example, one person's care plan stated the person was assisted to move with the aid of a rotunda (mobility aid). An assessment of the person by an occupational therapist stated staff had asked for a review as the person was unable to use a rotunda safely. The assessment stated a stand aid should be used. When we checked with staff we were told the person was now being moved with a hoist and spent most of their time in bed as they did not like the hoist. None of this information was in the person's care plan. In addition, the person had a urinary catheter and this was not mentioned in the person's care plans. Another person's daily log stated staff had applied creams after a fully body wash but this information was not recorded in the person's care plan. This meant there was a risk that people may have received inconsistent or inappropriate care and support.

People told us they were asked about their preferences of male or female staff to support them. Whilst people confirmed their preference was respected, we were aware that this had not been consistently provided for one person. We discussed this with the registered manager who explained the circumstances of this and the action taken to prevent this from reoccurring.

Feedback from our questionnaire told us 59% of people reported staff arrived on time. People spoken with told us they had not experienced a missed call. A person said, "I have never had a problem with them (staff) letting me down with calls at all." Another person said, "Their (staff) times can be all over the place but they have never missed me out."

However, people told us staff often arrived late. Whilst people understood this was sometimes unavoidable they were not always informed in advance that their call would be late. A particular frustration for some people was that staff did not provide calls at the time that was initially agreed at the start of using the service. People's daily log books confirmed what we were told, they received the duration of visit as per their

contract, but the time of arrival of the staff differed widely on occasions.

We received positive feedback from people who used the service about the duration of calls, 82% of people reported that staff stayed for the agreed time, and 88% of people told us staff completed all tasks expected of them.

People were not generally supported with activities to pursue interest and hobbies however, a relative gave an example of a social call that was provided to their family member. They told us the call was to give them a break from their caring role. They said the staff member played cards with their family member because this was one of their favourite pastimes.

We asked the management team how they met the Accessible Information Standard. This standard expects providers to have assessed and met people's communication needs, relating to a person's disability, impairment or sensory loss. The provider was meeting this standard. People's communication and sensory needs had been assessed and planned for. The service user guide that informed people about what they could expect from the service was available in an easy read format. The service director told us information was not provided in alternative languages, braille and audio. However, they would raise this with senior managers with a view to providing this information where required to ensure the service was fully inclusive.

People had a copy of the provider's complaint procedure. 71% of people that responded to our questionnaire knew how to make a complaint. Feedback from people we spoke to was overall positive about how complaints were responded to. A person said, "I have never complained as such, just niggles about two carers I didn't get on with. I rang the office and they didn't send them again, so yes, I'm very satisfied with their response." One person told us they had tried to complain about their visit times, but no changes had been made by the service leaving them frustrated. We shared this feedback with the management team who agreed to follow it up.

The provider's quality manager investigated complaints. The complaints log showed five complaints had been received since the service had registered in 2017. Information included the type of complaint and investigation outcome. This enabled the registered manager and senior management team to review any common themes and patterns to complaints being made.

The registered manager told us no person was at the end of their life, we were therefore unable to review an end of life care plan. However, a staff member told us that if they supported a person at the end stage of their life, an end of life care plan was developed with the person and they ensured the person was as comfortable as possible.

Requires Improvement

Is the service well-led?

Our findings

The provider had procedures and processes in place to assess people's needs. Communication systems were in place to inform staff of how to meet people's needs, and checks to assess the quality of the service. However, these were not as effective as they could have been. For example, people's care plans had not always been updated as required to inform staff of changes to people's needs. People's needs had been assessed, however, information did not always provide staff with sufficient detail. This included the impact of people's needs on them and what staff needed to be aware of to provide effective and responsive care. Spot checks were completed to assess staff's practice but these were not completed at the frequency the provider had identified as required or were sufficiently detailed.

The provider had processes in place to gain feedback from people who used the service. This included contact with the person six weeks following the commencement of their care package. However, the registered manager said this was not consistently being completed. 'Snappy' questionnaires were expected to be completed by care coordinators each month for a number of people. This was a method used by the provider to seek the views from people about the service they received. However, these checks were not completed at the frequency the provider had identified as required. This meant the provider was not following their own guidance.

Staff identified some shortfalls with communication within the organisation. They said if they talked directly with their care coordinator issues were dealt with, but if another person answered messages these were not always passed on. Additionally, if they had been told their care coordinator would phone them back it did not always happen. For example, one staff member said their line manager was, "One of the best." They said, "She will try and help as much as she can. However, messages aren't always communicated on." We had similar feedback from other staff. Staff told us staff meetings were infrequent and not all staff attended. We saw a copy of meetings provided in February 2018 that showed discussions were had with staff about quality standards expected of them. The registered manager told us staff that were not present received a copy of the meeting records.

Some staff were aware of the whistleblowing policy but some did not know when it would be used. A 'whistle-blower' is a person who exposes any kind of information or activity that is deemed illegal, unethical, or not correct within an organisation.

The management team agreed with our findings. A report completed in April 2018 by the provider's internal auditor showed the shortfalls identified during this inspection, had already been identified. An action plan had been developed that identified the action required by whom and target date for completion. Regular meetings were in place with the registered manager and senior management team to discuss and review the action plan and any other issues or concerns. This meant the provider had continued oversight of the service and there was accountability and a commitment to drive forward improvements.

The overall feedback from people who used the service was positive with the majority of people saying they would recommend the service to others. The shortfalls people identified were that calls were not always on

time and when staff were running late, this was not always communicated to them. All staff were described as being good but people preferred to have regular staff provide their care. People could not all recall that senior staff conducted staff spot checks and contact with the office was overall, not always a positive experience. Office staff were described as friendly and polite but issues raised by people were not always responded to in a timely and efficient manner.

Staff were positive about working for the provider. One staff member who had worked for other community care providers told us it was the best company they had worked for. "They make more time for you as a carer and I always get my hours." Another staff member said they were, "Treated very well." A third staff member said, "I love my job it's so rewarding." A member of staff said there had been a lot of change for the better over the last year. They said the service was more organised, improvements had been made to record keeping such as the use of electronic records meaning hand written care plans had been replaced with electronic ones.

82% of people who replied to our questionnaire told us they received opportunities to share their feedback about the service. The provider's quality manager told us how bi-monthly customer surgeries had been introduced. This was to try and engage with people about their views about the service they received and what improvements the provider could make. However, the quality manager told us there had been very limited uptake from people. The provider also sent annual questioners to people who used the service. We identified these were not provided in alternative formats that people may have found useful. The last survey was completed in 2017 and the findings were analysed. Where people raised specific concerns about their care this was followed up by a care coordinator. A customer newsletter was also sent to people that informed them of the survey results with other helpful information such as the office opening hours and out of hours contact.

Partnerships had been developed with a range of health and social care professionals. This promoted people's wellbeing and referrals were made when required. A professional said, "I have found them (service) to be very proficient when it comes to communicating about citizens. They have always gone above and beyond to try and accommodate a new care package when it's been urgent." They added, "Concerns are always brought to our attention immediately and professionally dealt with and any issues or concerns brought to their attention are usually dealt with very swiftly and efficiently."

The provider and registered manager understood the responsibilities of their registration with us. They reported significant events to us, such as safety incidents, in accordance with the requirements of their registration.