Britannia Homecare Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was announced and took place on 07 June 2016.

Britannia Homecare Limited is a large domiciliary care agency that provides personal care to people in their own homes who live in and around East Surrey. People who receive a service include those living physical frailty or memory loss due to the progression of age. The agency also provides services to people living with dementia and people with mental health needs. At the time of this inspection the agency was providing a service to 266 people of which 188 were receiving personal care as part of their package of care. Visits ranged from 15 minute calls to nine hours.

During our inspection the registered manager was present. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

People we spoke with were generally happy with the service they received and complimented the care workers who supported them. People felt they were treated with kindness and said their privacy and dignity was always respected. People's care and support plans contained information about what was important to them and how care should be delivered. People were involved in reviewing care plans with members of the management team.

People had mixed views about the timing of their visits but said that recently these had improved. The agency had taken steps to make the required improvements. Work in this area should continue. We have made a recommendation about this in the main body of our report.

Care workers knew how to keep people safe. They understood their responsibilities under safeguarding procedures and were confident the management team would act swiftly and deal with any issues appropriately. Recruitment procedures ensured care was provided by staff who were safe to support people in their own homes.

People said that they were happy with the support they received to manage their medicines. The agency had systems for medicine management that would benefit from further development to offer greater protection to people. We have made a recommendation about this in the main body of our report.

People's consent to care and treatment was considered. Staff understood the requirements under the Mental Capacity Act 2005 and about people's capacity to make decisions.

Risks to people had been identified and assessed and information was provided to staff on how to care for people safely and mitigate any risks. Development of risk management procedures will offer further protection to people. We have made a recommendation about this in the main body of our report.

People were happy with the support they received to eat and drink. Changes in people's health care needs and their support was reviewed when required. If people required input from other healthcare professionals, this was arranged.

Complaints and concerns were investigated and responded to appropriately. People who used the service felt able to make requests and express their opinions and views. A formal complaints process was in place that people were aware of.

The registered manager was committed to continuous improvement and feedback from people, whether positive or negative was used as an opportunity for improvement. Quality assurance systems were in place and used to monitor the quality of service provided to people. Further development of aspects of quality monitoring will help to drive improvements. We have made a recommendation about this in the main body of our report.

Care workers were committed and said that the registered manager and the management team were approachable and supportive. Care workers were supported to provide appropriate care to people because they were trained, supervised and received appraisals. They felt confident with the support and guidance they had been given during their induction and subsequent training.

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.

People had mixed views about the timing of their visits. The agency had taken action to address this however further work is recommended. There were safe recruitment procedures to help ensure that people received their support from care workers of suitable character.

People's medicines were managed safely. Risks to the health, safety or wellbeing of people who used the service were addressed in a positive and proportionate way. Development of risk management procedures will offer further protection to people.

People were protected from harm. People had confidence in the service and felt safe and secure when receiving support.

Is the service effective?

Good

The service was effective.

People confirmed that they had consented to the care they received. Procedures were in place to ensure people's legal rights were upheld and staff received guidance on the Mental Capacity Act 2005.

Care workers were provided with training and support to ensure they had the necessary skills and knowledge to meet people's needs effectively.

People were supported with their health and dietary needs.

Is the service caring?

Good

The service was caring.

People who used the service valued the relationships they had with care workers and expressed satisfaction with the care they received. People felt that their care was provided in the way they wanted it to be and that they were involved in making decisions about their care and support.

People were treated with dignity and respect and were encouraged to be as independent as possible.

Is the service responsive?

Good

The service was responsive.

Apart from the timings of some visits people felt the service was flexible and based on their personal wishes and preferences. Changes in people's needs were recognised and appropriate; prompt action taken, including the involvement of external professionals where necessary.

Assessment and care plans were focussed on the individual needs and wishes of people. A system was in place to the review the care people received that included consultation.

Systems were in place to make sure people's complaints and concerns were investigated and resolved where possible to the person's satisfaction.

Is the service well-led?

Good

The service was well-led.

People who received a service, their relatives and healthcare professionals said that improvements were being made to the quality of service provided. Formal processes were used to monitor and audit the service that included obtaining and acting on people's views. Further development of aspects of quality monitoring will help to drive improvements.

The registered manager promoted a person centred culture. Staff were proud to work for the service and were supported in understanding the values of the agency.

Britannia Homecare 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 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 inspection took place on 7 June 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to ensure that someone would be available. The inspection team consisted of four inspectors who had experience of caring for older people and domiciliary care services. Two of the four inspectors visited the agency office and three spoke to people who received a service and their relatives and staff by telephone.

Before the inspection, we asked the provider to complete 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 improvements they plan to make. We reviewed the completed PIR and we checked information that we held about the agency and the service provider. This included information from other agencies and statutory notifications sent to us by the provider about incidents and events that had occurred at the agency. A notification is information about important events which the provider is required to tell us about by law. In addition to this, we contacted 22 health and social care professionals to obtain their views of the agency. Eight of the professionals responded and we have included their views in this report. We used all this information to decide which areas to focus on during our inspection.

During the inspection we spoke with 21 people who received care and support from Britannia Homecare Limited by telephone and eight relatives. We also spoke with seven care workers by telephone.

Whilst at the agency office we spoke with the registered manager, an assistant manager and three care co-ordinators. We also reviewed a range of records. These included care records for eight people and other

records relating to the management of the domiciliary care agency. These included eight staff training, support and employment records, minutes of meetings with staff, policies and procedures, accident and incident reports and quality assurance audits and findings.

We last carried out an inspection of Britannia Homecare Limited on 14 May 2014 and found no concerns.

Requires Improvement

Is the service safe?

Our findings

People's views varied about visit times. One person said, "Sometimes the carers are early, sometimes they're late. I don't go out so it doesn't matter to me. There was once a time when no one turned up. I contacted head office and they soon sorted it out." A second person said, "Usually pretty good. They're very busy people. They normally stay the required time. If I need extra time they would give it." A third person said, "They're ok. The workers are fine. Timing is poor. Understaffed, especially with holidays and sickness. Quite often late." A fourth person said, "Fairly reliable. Variable timeliness. Generally phoned if carers are going to be late. Sometimes late. Sometimes early. 10 am and 5 pm calls are quite challenging with the traffic." A fifth person said, "Time of arrival is a bit erratic. They make sure everything is right before leaving though." A sixth person said, "They're quite reliable, I'm quite happy."

Some people told us that the timing of visits had improved within the last two months. One person said, "Things have improved. Usually on time now." A second person said, "Sometimes not here till 3.00pm. Not lately though. Things have improved."

Four health and social care professionals said that they were aware that there had been issues with the timing of calls and the lateness of some visits but that this had improved in the last two months. This was confirmed in data supplied to us by the agency. In February 89% of visits had taken place on time, in March this increased to 93% and in April this increased again to 94%. A visit was classified as late if it occurred more than 15 minutes after the agreed time.

The registered manager acknowledged that there had been issues with the timing of visits. They explained, "We were having a problem with lateness of calls. We have had a shortage of workers." To address this the registered manager explained that they had reduced the numbers of new care packages and would not take on a new care package if there were insufficient care workers to do this. In addition, the agency had been working with Surrey County Council to improve its systems and structures for ensuring people received their visits within safe timeframes. The agency had recently introduced travel time between visits for some areas such as Dorking as it had been identified that the traffic in this area impacted on care workers being able to carry our visits at the agreed times. During April 2016 staff meetings were held for the main purpose of discussing call monitoring and the timings of visits. It was reinforced that care workers should stay for the full agreed visit time in order to provide safe good quality care.

The agency used electronic software system for planning care workers rotas and for monitoring that visits took place at the agreed time. This was linked to mobile phones that care workers used which logged times of arrival and leaving at people's homes. The system also identified if a care worker had not arrived for an agreed visit. Whilst at the agency office we observed that the care coordinators checked this system and made contact with people if the system identified that a care worker was late for a visit.

It is recommended that the registered provider continues to review systems and structures in order to improve visit call times.

Recruitment checks were completed to ensure care workers were safe to support people. These included checks having been undertaken with the Disclosure and Barring Service (DBS). These checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people. Other information obtained included proof of the person's identity, references, proof of identification and a recent photograph. Records were also in place that confirmed care workers vehicles were safe to use when traveling to visit people in their own homes.

People were happy with the support they received with their medicines. One person told us, "I have medication in the morning. They (the care workers) help me with this. I have some with yogurt as it is unpalatable, which they help me with." A relative said, "No problem. Anything needed they ring me. X (family member) was confused when to take medicines. Carers help her to take medication much more regularly and when it is prescribed."

Care workers were able to describe how they safely supported people with their medicines. One care worker said, "Medication information is in the red folder. All meds info is printed out. A lot of the medication is blister packed. We cross reference information from blister pack and Mar sheet, I'm a stickler for this. Gloves must be worn. A lot of the clients like to know what they are taking so it's quite nice to explain this. This makes clients more relaxed in taking their meds, which is fantastic. We have regular training on meds by our fantastic trainer." A second care worker explained, "We check labels for names, medication and what it's for. We record it on a MAR sheet. We obviously ensure there is a four hour gap between dosages."

There were up to date policies and procedures in place to support staff and to ensure that medicines were managed in accordance with current regulations and guidance. Medicine assessments considered the arrangements for the supply and collection of medicines, whether the person was able to access their medicine in their own home and what if any risks were associated with this. The assessments also considered potential risks such as whether medication could be left out for the person to take at a later time and if any 'as and when required' (PRN) medicine was prescribed and what circumstances this would be taken or offered. Details of people's GP, their pharmacist and allergies were included in their medicine profiles.

A self-administration risk assessment tool was used to identify any potential hazards for people that self-medicated. This was used when reviewing support in relation to whether people were able to manage their own medicines or not. One person's risk assessment identified they had severe memory loss. The second page of the medicine risk assessment indicated that care workers should administer medicine but the front sheet identified 'level 1' (prompting) support to be provided. The medicine risk assessment noted that medicine could be left out for the person indicating that care workers were not administering medicines. The care plan required care workers to prompt only for medicines. This did not take into account the memory loss noted. A self-medication risk assessment had not been completed for this person. We raised this with the registered manager who agreed the persons memory loss needed to be assessed in relation to medicines management and that records needed to clearly inform care workers if they should be administering or prompting the person to take their medicines. Other people's records we sampled contained assessments that had been completed in full.

Medicine administration record (MAR) charts were in place for people that care workers used to record when medicines were taken. The MAR charts included the administration of topical preparations, the site of application and PRN medicines. MAR charts did not provide for distinction to be made between medicines administered, whether care workers prompted people to take their medicines or whether medicines were left out for the person to take at a later time.

It is recommended that the registered provider reviews medicines procedures to ensure accurate records and processes are followed.

Care workers that we spoke with were able to explain the procedures that should be followed in the event of an emergency or if a person was to have an accident or to fall. This included checking for injuries, calling for medical assistance if needed and notifying the agency office and completing records. The agency operated an out of hour's system that people and staff could access to change aspects of peoples care package, raise concerns and notify of events. Records and discussions with staff at the agency office confirmed that action was taken when incidents and events were reported to ensure people received safe care.

Assessments were undertaken to assess any risks to people who received a service and to the care workers who supported them. These included environmental risks and any risks due to the health and support needs of the person. Risk assessments included information about action to be taken to minimise the chance of harm occurring. With regard to risk management one care worker explained, "Safety is a very wide aspect of care. From the time I walk in, a lot of people live alone, so they use key safe. After I use the key safe I also scramble the numbers as you never know who is around. When I enter the home I'm already safeguarding, assessing the situation, is the client happy and safe. It's about making sure the client is well."

Risks were rated as high, medium or low. Where risks were identified management strategies had been developed to help reduce these. Examples of such included staff numbers and the use of specified equipment (hoists and slide sheets). Where risks had been identified these were cross referenced with care plans. For example one person's risk assessment covered their mobility and this reflected the notes made in their care plan about how they should be transferred and how their mobility was sometimes reduced due to their mental health needs. We did note that the frequency which risk assessments were reviewed varied and was not always in line with the registered provider's policy. For one person who fell on three occasions a risk assessment was completed that was reviewed on one of the occasions and their care plan had not been updated. This continued to refer to the person as being able to walk independently with a stick whereas other documentation on file stated that the person now required a wheelchair to move about. This is an area for development that was acknowledged by the registered manager.

It is recommended that the registered provider reviews risk management procedures in order to offer further safeguards to people.

Emergency contingency plans were in place to ensure people continued to receive a service in the event of staff shortages, equipment failure and other events. People told us that information was provided when they first received a service that included emergency contact details.

Everyone that we spoke with said that they felt safe in the hands of Britannia Homecare Limited and the care workers who supported them. One person told us, "I feel quite content and safe." a second person said, "I absolutely feel safe. They're a very nice crowd. I feel very supported. I have no complaints." A third person said, "You have their number to report concerns." A relative said, "X (family member) is perfectly safe when being supported." A second relative said, "Definitely feel safe."

One social care professional wrote and informed us, 'They provide packages of care to a number of my clients. I have found them to work safely and effectively. Britannia will call me if there are problems and are willing to go that extra mile to ensure the client is safe and well.' A second social care professional wrote, 'Generally it is safe.'

A safeguarding policy was available and care workers were required to read this and complete safeguarding

training as part of their induction. Care workers that we spoke with confirmed they had received training and were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. One care worker said, "We make sure they're safe and not in any harm and there are no hazards. If I had concerns I would inform the team leader and social services."

Care workers also were aware of the agency's whistleblowing procedure and how this offered further protection to people. The registered manager understood her responsibilities in relation to safeguarding people from harm. Before this inspection, the registered manager had sent us information about safeguarding information when concerns were identified or raised about people's safety. The information included evidence of actions taken to address the concerns and reduce risks to people. We were also supplied with evidence that the registered manager discussed concerns with the local authority safeguarding of adults team and made referrals when necessary.

Good

Is the service effective?

Our findings

People were supported by care workers who had the knowledge and skills required to meet their needs. One social care professional wrote and said of a care worker, 'The staff member is supportive and honest with my client which has been a great help and support with many issues and she has to my mind helped to progress my client in a positive direction.' One person told us, "Carers are most definitely knowledgeable." A second person said, "X (care worker) is very, very good. Exceptional. Looks after me right from the go. They're all very good." One relative said they thought care workers had robust training and after that they, "Shadow an experienced member of staff for at least a week." They went on to say of care workers, "They know their stuff."

All new care workers completed an induction programme at the start of their employment. Care workers confirmed that they had completed an induction that helped equip them with the knowledge required to support people in their own homes.

A comprehensive training programme was in place that included courses that were relevant to the needs of people who received a service from the agency. The agency employed a qualified trainer to ensure care workers received regular training and updates. Care workers had received training in areas that included dementia care, dignity and respect, equality and diversity, fire safety, first aid, malnutrition, food hygiene, moving and handling, palliative care and infection control.

In addition some staff had either completed a National Vocational Qualification or were completing training linked to the Qualification and Credit Framework (QCF) in health and social care to further increase their skills and knowledge in how to support people with their care needs. At the time of inspection three members of staff were completing the Diploma level five in Health and Social Care, six staff the Diploma level three and 11 staff the level two Diplomas.

Staff received support to understand their roles and responsibilities through supervision and an annual appraisal. Supervision consisted of individual one to one sessions and group staff meetings. Supervision included formal spot checks of care workers when supporting people in their own homes. We did note that some care workers had not received formal supervision at the frequency stated in the agency policy. This was acknowledged by the registered manager as an area for future development. Despite this all staff that we spoke with said that they were fully supported. One care worker said, "I very much feel supported through regular training and supervision." A second care worker said, "I am supported. If I need extra training it's always available." A third care worker said, "It's been very informative, taught me things I wasn't aware of. At Britannia the trainer supports you until you are signed off. Having a single reference point and point of contact was useful as a new employee."

People were happy with the support they received to eat and drink. One person said, "They prepare my meals for me. I can feed myself though." A second person said, "They always make sure I have a cup of tea. Always water in the kettle. Leave a couple of tea bags out on the side. Son in law sorts out meals and shopping." A third person said, "They help me up in the morning. Breakfast and drinks, Lunch and another

drink. Evening meal and another drink and back at night for another drink. Very helpful."

People were supported at mealtimes to access food and drink of their choice. The support people received varied depending on people's individual circumstances. Some people lived with family members who prepared meals. Care workers reheated and ensured meals were accessible to people who received a service from the agency. Other people required greater support which included care workers preparing and serving cooked meals, snacks and drinks. For example, one person had fluctuating levels of dependency. Their care plan noted that care workers needed to take this into account as the person often preferred to cook their own meals if they were feeling up to it. The care plan went on to note that care workers needed to do this for them if they were having a bad day but that they must ask the person what they wanted prepared for them. Care workers confirmed that before they left their visit they ensured people were comfortable and had access to food and drink.

Care workers were available to support people to access healthcare appointments if needed. They also liaised with health and social care professionals involved in their care if their health or support needs changed. One social care professional wrote and informed us, 'Management do concern themselves with the clients wellbeing and will raise concerns in the event of incidents occurring, hospital admissions and health issues relating to the client.' Information was included in people's care plans of healthcare professionals involved in their lives. This included details of their GP and district nurses. Correspondence was on people's care records showed that the agency
maintained links and communicated with people's GP's, district nurses, mental health nurses and hospice nurses in line with meeting their needs. Care workers confirmed that they and members of the management team liaised with the relevant healthcare professionals where necessary to ensure people received a consistent service.

People confirmed that they had consented to the care they received. They told us that care workers checked with them that they were happy with support being provided on a regular basis. One person told us, "Female carer asked me 'can I do this, can I do that'. She explained it was part of her training." A second person said, "When I get up in the morning they ask me if it's OK to get me up." A relative said, "They (the care workers) do ask you. They don't dictate."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the agency was working within the principles of the MCA. Staff received Mental Capacity Act training and were able to explain what consent to care meant in practice. One care worker explained, "Everyone is able to make own decisions unless they don't have capacity. If a person lacks capacity we work with doctors, family, social workers to get the best package." A second care worker said, "It's whether they can make decisions on their behalf. It's about making own choices."

People's ability to consent was considered at the initial assessment stage of their care package. People had signed and dated their initial assessments, care plans and risk assessments. This indicated that the care planned was discussed with people and that they consented to what had been written. Care plans made reference to and emphasised the importance of care workers asking people for permission prior to doing things for them in their homes. One person's care plan specified very clearly that furniture and fittings should not be moved about. This was because the person was visually impaired and doing so would create risks and impact on their level of independence. When a care worker noted a rug was frayed and a potential trip hazard the person's permission was sought and granted to remove the frayed ends which meant it was

made safe without it being removed or replaced.

Good

Is the service caring?

Our findings

People told us they were treated with kindness and respect by the care workers who supported them. One person told us, "Carers are lovely, they are caring and they couldn't be nicer. I normally have the same people, which is good for me. I am more than happy with the support." A second person said, "All very kind and helpful. I couldn't open a tin of prunes this morning and the care worker opened it for me. I have consistent carers coming in." A third person said, "All very kind and caring."

One relative said, "Carers are always friendly and things get dealt with." A second relative said of one care worker, "She is brilliant. She is caring and makes him laugh." A third relative said, "Professionalism is spot on, they put my parents at ease and are good at communication."

One social care professional wrote and informed us, 'Individual carers can show considerable care to clients.' A second social care professional wrote, 'My client has the same Britannia staff each day, and they have built up a trusting and knowing relationship.' A third social care professional wrote, 'My clients feedback that the care workers themselves are caring.'

Positive, caring relationships had been developed with people. one person told us how they tended to get the same care workers visit them and that this, "Helps with relationships." A second person told us of the care workers who visited them, "(They) always listen and take notice of what I need." Care workers understood the importance of building positive relationships. One care worker explained, "It's about treating and speaking to someone the way you would expect to be treated and spoken to. It's about asking them; always make sure they're covered. It's just respect. Make sure they are dry and clean and clothes put on as soon as possible. Treat them as an individual. Everyone is different. It's their choice. They're in control. Listen to them. Respect their privacy." A second care worker said, "I always ensure doors are closed, curtains shut, embarrassing areas are covered, talk to them, talk about a comfortable subject to put them at ease."

Care workers were respectful of people's privacy and maintained their dignity. One person told us, "Very good in that respect. Show me a lot of dignity. I don't like being exposed. They know that." Care workers told us they gave people privacy whilst they undertook aspects of personal care, but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls. With regard to privacy and dignity, one care worker explained, "We ask them. Each time I go into a call I ask them what they like to be done. We have person centred care. I have a lady that sometimes she likes to be hoisted and other times she does not. When she doesn't we risk assess whether she can stand up and use her frame. It's her choice. I close curtains and doors. Make sure there is no one else they don't want in the room."

People said that care workers helped them to maintain their independence. One person told us, "With their help and that of the physiotherapist I can now walk to the lounge and bedroom and back. A lot of this (improvement) is down to the help I have received from Britannia." A relative also said that care workers helped their family member to maintain their independence. They explained, "If X (family member) wanted to do something they don't stop him as long as he is safe. They help him stand up and move about."

Dignity and independence were reinforced as two of the main values of the agency within its statement of purpose and service user guide. Care workers received guidance during their induction in relation to dignity and respect and their practice was assessed when members of the management team completed spot checks in people's homes.

People were supported to express their views and to be involved in making decisions about their care and support. One person told us how they had requested male only care workers and this had been provided. A relative told us that the agency had involved them when their family members care package started and at each review thereafter. People signed their care plans to confirm they had been involved in their compilation and review.

Good

Is the service responsive?

Our findings

People's care and support was planned in partnership with them. People said that when their care was being planned at the start of the service a member of the management team spent time with them finding out about their preferences. This included what care they wanted or needed and how they wanted this care to be delivered. One person told us, "Quick response, they started support that day." This person went on to tell us how they were very impressed with how quickly the agency could support them after being referred to them. A second person said, "They discussed with me and my son and I signed. I was involved in the planning initially and when changes have happened, e.g. after admission to hospital."

One social care professional wrote and informed us, 'I think that their assessment process for new clients is comprehensive and professional. They don't take on care unless they have seen the prospective client, this is good practice.'

Apart from the timings of some visits people received care that was responsive to their individual needs and preferences. One person told us, "I sometimes ask if they (the care workers) don't mind putting my washing on. They often ask if there is anything else they can do for me." A second person told us, "I started only having a hair wash and back wash. I now have a shower. They (the care workers) manage that." A relative told us, "My husband was being verbally aggressive towards one carer. This was appropriately responded to when an experienced carer asked the carer who was being targeted to wait outside. This reduced anxieties and the situation was managed. They understand my husband's needs. They (the care workers) have a chat. Go along with his fantasies, which really helps him." A second relative said of the agency, "Very good to deal with, always helpful and responsive."

One social care professional wrote and informed us, 'Often managers will come out to the reviews and they know my clients well and it's obvious they have had full hand overs from the regularly attending staff. Britannia will call me if there are problems and are willing to go that extra mile to ensure the client is safe and well.'

Care workers were knowledgeable about the people they supported. They were aware of their preferences and interests, as well as their health and support needs. This enabled them to provide a personalised and responsive service. Assessments were undertaken to identify people's support needs and care plans were developed outlining how these needs were to be met. These were reviewed on a regular basis in accordance to people's changing needs. One care worker explained how a person they supported had a stroke and lost the strength in their muscles. As a result, specialist equipment was arranged to help them mobilise and to maintain their independence. The agency's trainer then delivered bespoke training to the care workers so that they could support the person effectively and in response to their changing needs.

Another care worker explained that they supported a person who lived with dementia. They explained that the person did not like authority figures. As a result, the care worker explained that they changed their approach to fit the needs of the individual. As this person liked the "friendship side" the care worker said they had "Harnessed this and I have been able to engage with them more on the tasks that the gentleman

needs support with. In this job you need to be adaptable, go in with an open mind, and approach in a way that is best for them."

Care workers confirmed they were kept informed about the changes to the support people required. They said that they received telephone calls, text messages and emails from members of the management team that informed them of changes. They also said that they were required to read care plans and other care related documents on a regular basis as these were updated when a person's needs changed.

Care plans were person centred. They focussed on the individual needs and wishes of people. Descriptive sentences were used to help make it clear to care workers how people wished to be supported. For example care plans routinely included sentences starting with, 'I would like…; I am unable…; I am able…; Please change my…; and be careful when…'

Care plans clearly specified what people liked to do for themselves. Care plans noted that care workers should take into account and provide for people's varying or fluctuating levels of independence or dependency on their good and bad days. For example, one person's care plan noted 'cognitive issues' had at times an impact on their mobility. Another person's care plan included different interventions to be followed depending on that person's presentation and needs on the day. The person had cancer, received palliative care and had good days and bad days. The care plan took this into account. Care plans included a degree of flexibility in so much that they noted that additional support should be provided if required and if within the scope of the person's support plan and risk assessments.

If peoples care packages were funded by Surrey County Council (SCC) the contents of the local authority care plan cross referenced with and matched the care plan developed by the agency. Email records on file showed that the agency communicated with SCC case managers where changes in people's needs were noted. For example, one person requested their evening call was cancelled. This was communicated to SCC and care plans were updated to reflect this. Another person's increased independence in taking care of their own self, preparation of food, and domestic chores was noted, shared with the SCC case manager and again care plans were updated.

People's preference for male or female care workers was noted in their initial assessments and care plans. People said that their preferences had been met nearly all of the time. When they had not then they had told the agency they were unhappy and this was listened to and acted on. Where two care workers were required this was specified in peoples care plan. Cross checking care plans with visit records showed that where two care workers were specified these had been provided.

A system was in place to review the care people received. The review provided for consultation with people using the service, their representatives and other professionals that may have been involved in the formulation of the care package. The review included accuracy of documentation, and planning and support in relation to medicines. It also covered goals and outcomes, care workers attitudes, if privacy and dignity was respected, any complaints and overall levels of satisfaction.

People were encouraged to give their views and raise concerns or complaints. People using the service and their relatives told us they were aware of the formal complaints procedure and that they were sure that the agency would address concerns if they had any. One person told us, "I would speak to Britannia directly or my care manager if I had any concerns. I've had nothing to compliant about so far." A second person said, "I have the office number, so I suppose I'll call that." A relative said, "I would ring Britannia, Britannia will always sort it." One social care professional wrote and informed us, 'I mostly find that they polite and friendly on the phone and they do respond when you raise an issue or concern.'

One relative told us of their experience when they raised concerns with the agency when male care workers were sent to their family member when they had requested female care workers. They said, "Had a few problems, I spoke to them, I spoke to my care manager, it's all sorted out now." They went on to say, "It's been a couple of months since they last sent a male carer." Another person told us that they were satisfied with the way their concerns had been dealt with by the registered manager. They said, "Nothing other than the timeliness of calls. Have rung up and met with X (registered manager) to discuss concerns. Have listened to and addressed the issue. All ticking over great now."

The agency had complaints procedures in place to respond to people's concerns and to drive improvement. The agency's complaints process was included in information given to people when they started receiving a service. There was a record in place of formal complaints received, investigations undertaken, outcomes and apology where necessary. This stated that for 2016 eight formal complaints had been received. Six of these related to visit times. The timing of visits had been recognised as a common theme by the registered manager in the PIR that was submitted to us. Actions that had been taken to resolve this included greater monitoring of visits using the electronic visit planning system and more communication with care workers. We were informed that informal concerns were followed up and recorded on people's individual records and those we sampled confirmed this. These were not included in the formal complaints log and is an area for future development.

Good

Is the service well-led?

Our findings

People said that the agency had gone through a period of change but that improvements had been made and that they were generally satisfied with the service provided. One person said, "Very well overall. Good quality care." A second person said, "Pretty good." A relative said, "I am very impressed. I do approve of Britannia."

People also said that communication with the members of the management team and staff at the agency office was good. One person said, "It's been good. They're very attentive. They listen." A second person said, "Very good. Feel listened to. Always someone there on the other end of the phone." A third person said, "Effective communication to and from."

A healthcare professional wrote and informed us, 'I have been able to develop a very positive relationship with all the team at Britannia, especially X (member of staff). X has been the main point of contact for my requests for carers. I would especially commend X for her excellent telephone manner.' A social care professional wrote and informed us, 'The service is well led - both owners are visible to staff, partners and people that they care for and the registered manager has been in post for a long period of time.'

There was a positive culture at the agency that was open, inclusive and empowering. Care workers spoke highly of the registered manager and the company. One care worker said, "I've worked in care 16 years, Britannia is one of the best companies I have worked for. They are fantastic and great. Great with holidays, sickness can be high, they cover the shifts." A second care worker said, "It's a good place to work. No complaints. Easy going." The views of staff reflected the findings from the staff satisfaction surveys that were carried out in March 2016. For example, 73% of staff who completed a survey gave a positive response and 23% a fair response.

One care worker told us of changes that had been made to the management of the agency and expressed the view that these had improved communication. They explained that the office staff were now organised into specific areas, and that as a result could offer better advice and support. They added, "It's much easier for staff now as we know who to talk to and go to for help and advice and the quality of that support has improved a lot." This was confirmed when we visited the agency office. The staff structure included care coordinators who had responsibility for five designated geographical areas and assistant managers with specific roles such as medicines management and hospital admissions.

Care workers were motivated and told us that they felt supported and that they received regular support and advice via phone calls and face to face meetings. They said that the management team was approachable and kept them informed of any changes to the service and that communication was good. One care worker said, "I get supervision and appraisals and I'm definitely well supported. If I have any problems I have my manager or their manager. They're on tap, they give time. Every problem has been dealt with." A second care worker said, "Working for Britannia is alright. Being overloaded with calls can be a problem, although this doesn't happen often. I feel supported. If I need advice I ring them and they are always pretty good." At Christmas staff received vouchers from the directors of the agency in recognition of

the work they had undertaken.

Prior to our inspection the registered manager completed and returned the PIR as we requested. Evidence gained during the inspection reflected the contents of the PIR. This demonstrated that the registered manager was open and transparent about what the agency did well and areas that she had identified would benefit from improvement.

There were quality assurance systems in place in order that the agency could monitor and where needed improve the quality of service that people received. These included monthly statistical audits of accidents and incidents, daily checks for missed visits and call times, and a log of falls. Where needed action plans were in place to address areas that required improvement. Key performance indicators were in place for the registered manager and members of the management team in order that the agency could measure performance and if aspects of the service were being quality assured.

The agency obtained the views of people who received a service in the form of surveys and the findings were used to drive improvements and influence the quality of service provided. These were last completed in March 2016 when 176 people returned a completed survey. Of the 176 responses, 104 people stated they were 'always' satisfied with care. 66 people stated they were satisfied with the care 'most times', two people stated 'sometimes' and a further two people stated 'never'. Four people did not respond to this question. When asked if they would recommend the agency 108 people responded 'always', 40 'most times', 10 'sometimes' and six 'never'. Eight people did not respond to this question. The area where people rated most improvement was needed was visit times. The survey results indicated that people's satisfaction had increased since the last survey but that further work was required. Actions had been put in place to address this that included greater monitoring of visit times, better communication with people and a recruitment drive to employ more staff.

We looked at quality monitoring systems for medicines management as the PIR stated that there had been 46 medicine errors prior to September 2015. The registered manager informed us that a number of errors had occurred due to a lack of accurate information when people were discharged from hospital. As a result, the agency had made it a condition of accepting care packages that information about changes in medicines was received before commencing a service. We were also informed that additional medicine audits had been implemented and where necessary further training provided to care workers. Records and discussions with staff confirmed this. Monthly medicine audits were completed that looked at gaps in MAR charts for every person who received a service. When errors were identified these were investigated and action taken which could include further training for care workers. There was no overall analysis of the findings from the individual medicine audits to identify trends or themes. This is an area for development.

Although there were a number of audits and quality assurance processes in place along with action plans where needed the findings from these were not collated or incorporated into one overall plan.

It is recommended that the registered provider reviews the quality assurance processes in place in order to continue to drive improvements.

Care workers received feedback from audits and investigations at staff meetings in order that improvements in the quality of service could be made. For example, during staff meetings held in February 2016 care workers received detailed information about medicine management and errors, confidentiality and use of the on call system. During April 2016 staff meetings were held in order to discuss call monitoring and the timings of visits.

Britannia homecare Limited had clear vision and values that were person-centred and that ensured people were at the heart of the service. They included respecting the wishes and personal preferences of people and supporting people to remain in their own homes. The aims and objectives were included in the agency brochure which was given to people when they first started to receive a service.