Manorcourt Care (Norfolk) Limited

Manorcourt Home Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 25 September, the 9, 16 and 20 October 2017 and part of the inspection was announced. This was the first inspection on the agency since a change in its registration.

The service provides domiciliary support to people in their own homes. Most people are elderly but the agency are able to meet the needs of people over the age of eighteen. Support ranges from providing domestic help, personal care, social visits, sitting service and night sitting as appropriate.

At the time of our inspection there was a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

The feedback we were given from people receiving a service was very positive. People generally felt they got a good service and said staff were well trained and kind. People reported some concerns with late running of calls and said they did not have regular carers but lots of different carers. People told us they got to know all the staff. The service had four recorded missed calls in six months. which had meant people did not always get the support they needed. We were informed prior to our visit that one person had not been given their medication as a result of a missed call.

There were systems in place to help ensure people always received their medicines as intended. The service had medication officers who supported people who required support to take their medicines. Their role involved collecting and returning medications. Auditing medication and dealing with any potential medication errors. They also supported staff in administering medication and assessing their competencies. We noted from the audits that missed signatures of the persons medication records had been identified on numerous occasions. We were made aware of several medication errors which had been reported to the local authority safeguarding team and an internal investigation completed so lessons could be learnt. For one person missed medication may have resulted in a decline in their health although there were other mitigating factors. However systems and processes in place at the time had not been sufficiently robust to identify the error sooner which could of resulted in avoidable harm.

Care plans instructed staff on how to care for the person and what support to provide. These were up to date taking into account any changes to people's needs. However they could be more detailed which would help ensure a more consistent approach to care. For example it might identify that the person did not have smoke detectors but then did not go on to say how this was to be addressed or how this put the person at an increased risk due to other mitigating factors such as whether the person smoked in the property. Documentation could be in more detail to help the reader respond adequately to people's needs.

We had a concern about people's security. Personal data was not sufficiently protected particularly in relation to door entry systems. This was rectified immediately. When visiting people we were concerned

about the security arrangements some of which had not been identified or documented as a risk. This was fed back to the registered manager for their consideration.

There were systems in place to protect people from actual harm and abuse and staff were familiar with actions they should take if they suspected a person to be at risk of harm or abuse. People's safety was promoted within their homes because risks were assessed and steps taken to reduce the level of risk to people. Care plans included detailed of how to support people safely particularly with their manual handling requirements. Staff received training in all areas of practice before supporting people. This helped ensure staff had the necessary skills and competencies for their role.

The service had recruitment and staff selection procedures in place which were followed in practice this helped ensure that only suitable staff were employed Staff were given the necessary induction, training and support for their role.

Staff had received training in the Mental Capacity Act 2005 (MCA) and the Deprivation of Liberty Safeguards (DoLS). The MCA ensures that people's capacity to consent to care and treatment is assessed. If people do not have the capacity to consent for themselves the appropriate professionals, relatives or legal representatives should be involved to ensure that decisions are taken in people's best interests according to a structured process. DoLS ensure that people are not unlawfully deprived of their liberty and where restrictions are required to protect people and keep them safe, this is done in line with legislation.

Staff supported people with their assessed needs in relation to their physical and emotional care needs. Staff worked with other health care agencies to ensure changes to people's needs were recognised and the person supported to stay healthy. Where people needed assistance or encouragement with eating and drinking enough for their needs this was provided.

Staff provided care according to people's wishes and preferences and support that promoted people's independent and dignity. Staff were mindful of peoples back ground and factors which might influence the care to be provided such as ethnicity and religion. Gender specific care was taking into account in line with peoples preferences.

People were consulted about their care as part of the initial assessment and then through on-going reviews of their needs.

There was an established complaints procedure which people and their families were aware of. Everyone we spoke with felt able to raise any issues and were confident it would be dealt with.

The service had a registered manager who had worked hard to stabilise the service and recruit the staff they needed to deliver effective care. People had not always received the care they required but this had been identified and steps taken to improve the service. The service looked at what lessons could be learnt from any safeguarding investigation to help ensure mistakes were not repeated where they could be avoided. Medication errors had led to improved practice but people had been put at risk.

The service was firmly established in the community and worked hard to be a part of it and help ensure people knew how to access goods and services.

The service took into account feedback from people and stake holders about how they were performing and what they needed to work on and improve.

We found a breach of the Health and Social Care Act (Regulated Activities) Regulations 2014. You can see what action we told the provider to take at the back of the full version of the report

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

The service was planned around people's needs but occasionally the service did not deliver care as intended.

Risks to people's safety were documented and reduced as far as reasonably possible. However risks were identified in association with people's personal data and security arrangements.

People received their medicines as intended but a number of errors had occurred.

Staff received training to help them recognise what constituted abuse and what actions to take if they suspected it.

There were safe recruitment procedures in place to help ensure only suitable staff were employed.

Is the service effective?

Good

The service was effective.

Staff were supported through an effective staff development and training programme. This helped ensure they had the necessary skills and competence.

Staff supported people lawfully and offered them appropriate support. Consent was sought before providing care.

People were supported to help ensure their assessed needs were met in relation to the physical care needs and health care needs. Staff supported to eat and drink enough for their needs.

Is the service caring?

Good

The service was caring.

People using the service were confident in the staff providing the care.

Staff supported people in a way of their choosing and took into

account their wishes and views when providing care.

The service tried to promote the persons wishes and rights in line with their preferences and self-determination.

The service did the above through joint working with others to try and ensure they were providing personalised care.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and kept under review to help ensure they continued to receive the right level of support.

Care and support was designed to help people stay in their own homes and be as independent for as long as possible.

An established complaints procedure was in place and the service took into account feedback it received from people

Is the service well-led?

Requires Improvement

The service was well led.

Accident and incidents these were not effectively analysed and investigated to identify any trends or patterns. This was an area requiring improvement.

People told us they were happy with the service they received.

The registered manager was competent and supported her staff in terms of their self-development and competencies.

Regular audits helped ensure the service knew where the risks were and could plan to reduce them as far as reasonably possible and ensuring lessons learnt.

Reviews in place helped the service consider how the person felt about the care and the wider service and take this into account when planning and delivering it.

Manorcourt Home Care

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.

The inspection took place 25 September, 9, 16 and 20 October 2017. We started the inspection by telephoning a number of people using the service from a list provided from the service and with people's agreement. We carried out an inspection to the main office giving the provider 48 hours' notice. We then arranged to visit people using the service in their own homes. Following feedback we visited the office again to follow up on some things and give feedback.

The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection we looked at notifications which are important events the service are required to tell us about by law. Before the inspection the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make.

We reviewed seven people care plans, four medicine records, two staff files, rotas, minutes of meetings, training and supervision records and audits.

We spoke with eleven people over the telephone, spoke with two relatives and visited six people in their own homes. We had feedback from two care staff and one health care professional. We met and interviewed the registered manager, senior care coordinator, two team leaders, the medication officer and the my way coordinator who dealt with mostly the private clients.

Requires Improvement

Is the service safe?

Our findings

We spoke with people over the telephone to ask them about the service they received from the agency. We also visited people in their own homes. People were mostly satisfied with the support they received and people's care was mostly planned and delivered on time and in accordance with their needs. People told us they did not have a regular carer, some had up to seven different carers but said they got used to them and said they were all nice. People told us they had not had a missed visit but the times of the calls could vary which caused some inconvenience.

One person told us, "Things are going very well. I've had no problems. The timekeeping's fine and they do everything expected. I would recommend the service very much so." Another said things were working well other than the continuity in so far as it was not always the same person each week. People told us they usually knew who was coming in advance (via a rota) and it was a regular team of care workers. One person said, "Normally everything works well. I get a regular rota." Another said that the timekeeping was usually ok, but could sometimes vary, in terms of when the carer may turn up. One person said, "Sometimes they arrive at 11 to give me lunch, it's too early for lunch". Another person said, "I have four calls a day and sometimes they are too close together."

We looked at the staffing rotas and planning of visits. The agency operated half an hour each side of the planned visit time. This helped carers arrive as far as reasonably possible on time depending on traffic or dealing with unforeseen emergencies. Travel time was included between calls but some staff felt this was not always sufficient. As far as reasonably practicable senior staff planned the rotas ahead of time and used their local knowledge to plan calls in close proximity to each other and close to the carers address. Pressure arose at the weekends when there were less staff to deliver the care as some carers had every other weekend off and the agency reported they did not have less care calls. They employed three casual bank staff who picked up shifts when available including the weekend. There was no reciprocal relationship with another agency should they be unable to cover a call due to unplanned leave. Some staff said they were regularly working long hours. Staff employed in a management and administration role told us they were sometimes asked to cover care shifts which had an impact of their ability to complete other work. Staff sickness was covered by other staff working overtime and there were systems in place to support staff and monitor sickness.

The service had a registered manager, senior team leaders and team leaders and were advertising for a fourth and also an administrator. This would help ensure the service could cope with their growing business. The registered manager told us that the company managed both domiciliary care and residential care services and were planning to look at staff working across the whole company. The registered manager reported recruitment as robust and said they had been able to back fill posts for staff on long-term sickness. They were also able to give financial incentives to staff for introducing potential new employees.

We saw from records that there had been four missed calls over the previous six months. The registered manager told us there was an analysis of this to try and prevent it happening again and said it was an improving picture. However, missed calls have the potential to expose the person to unnecessary risks

depending on the person's individual circumstances. By this we mean some people were dependent on the care provided to them to assist them with meals, personal care and day to day tasks. Other people might require minimal support with domestic care. We received information prior to our inspection of two missed calls to the same person which had resulted in them not getting their medicines as required. The impact of this was minimised as they had family supporting them who was able to identify this and support them accordingly. Not everyone had regular input from family so the risk could be greater.

Some people said they were not always notified when a carer was going to be late. The service had an electronic record system which they used to plan and allocate calls. This meant they could see where carers should be at any given time. However it was not possible using this system to track carers movements when travelling or when they entered and left a person's address. There is a tracking system which can be used by having an app on a smart phone which carers scan as they enter and leave a person's property. The registered manager said they were going to trial this at one of their branches and if successful look to roll it out. They did point out that the mobile signal in some of the remote areas of Norfolk would be an issue. They told us they currently monitored call times by going through the daily notes kept for each person. These were collected by the team leaders and transferred to the office and checked for any discrepancies. They also told us they checked staff rotas against the staff time sheets. However staff told us people receiving care did not always sign the time sheets and the reasons for this had not been fully explored. This should be addressed.

In the event of an emergency the service had an on call system which was covered by a minimum of three staff who might be senior staff and, or experienced care staff. One staff member told us there had been times when they were covering care calls whilst retaining the responsibility for the on-call. We raised this as an issue of confidentiality as staff could potentially be delivering care whilst be expected to answer the telephone. The registered manager said there was always more than one member of staff on call so this situation should not arise.

We had concerns about how potentially sensitive information was being managed. On call staff carried information around with them which if found by a person not related to the business would potentially compromise people's identity and safety. Immediately following our inspection this was rectified. The registered manager provided us with evidence of actions taken to update staff and revisit the procedures and policies they had in place.

Whilst visiting people we found access to properties did not always provide people with sufficient security as doors were unlocked. We could not see from the paperwork in people's homes that the risk of an unlocked door had been fully considered. Some people had key safes but again we could not see if this had been discussed with everyone using the service that might benefit from this. However following the inspection we were provided additional information to show security and key holding arrangements were discussed with people.

We looked at the arrangements in place for managing and supporting people with their medicines. The organisation had medication officers who collected and checked people's medicines on a monthly basis. People were happy with the arrangements in place for their medicines. One person told us they received support with their medication twice a day and indicated that the system worked well and they had not had any issues.

Risk assessments and medication records were put in place where staff supported people with their medicines. There was a list of medicines people were taking and a separate record for creams. Staff received training both at induction and throughout their employment to make sure they were competent to support

people with their medicines. They completed both internal and external training. The medication records were collected on a monthly basis and checked for accuracy. There were a number of missed signatures which had resulted in identifying the staff responsible and providing them with additional training. There were also spot checks on staff where their competencies would be checked to ensure they were following correct policy and procedures when giving medicines. We looked at monthly medication audits which had identified gaps. These were not always being completed monthly as intended. Gaps in auditing meant errors might not be identified in a timely way. We reviewed people's care plans which did not give any additional information about how people would like to take them. The manager said this was in line with the Local Authority's medication policy.

On our visits to people we noted a number of people taking their medicines independently and some people had a lot of medicines. One person was described as stock piling their medicines and we could not see if the risks of them doing so had been considered. Another person told us they were taking antibiotics but we could not see this recorded in their records. Monthly medication audits did not include a full audit of prescription creams. We saw a person on pain patches and clear instructions for carers to rotate the site of the patch to stop the skin breaking down. However there was no body map to indicate where the patch was being applied. This is poor practice.

Prior to offering a service an assessment of need and assessment of risk was carried out. This looked at any potential hazards when delivering care both to the person and to the member of staff providing the care. The assessment looked at the persons specific needs and the environment in which the care was being delivered and any equipment necessary. If the person required support with moving, staff had received the required training and a plan was put in place telling staff how to assist the person safely. The plans did not always go into enough specific detail. For example where people had long term conditions such as Parkinson's disease, dementia or diabetes the plan did not specify the impact it had on the person or if there were any considerations for the carers. We spoke with one person who had Parkinson's disease and their mobility in the morning was very slow. They required their medicines on time and this was to be taken and given time to work before they got up and prepared for the day. This level of detail was not seen in people's care plans which would enable staff to respond appropriately to people's individual needs. The provider told us that staff had access to guidance about specific conditions and training to enable them to appropriately support people.

With regards to the risk assessment again a lack of detail meant we could not always see if there was a risk or how it had been mitigated. For example the form might indicate the person did not have smoke detectors in their property but not what risk that posed or if there was an increased risk such as did the person smoke. The registered manager told us as far as possible they sign-post people to other services. For example the fire service will visit people's property and fit and test smoke detectors. The provider sent us evidence to support this.

We reviewed the accident record book which included a few accidents staff had when delivering care. These were appropriately recorded. However accidents and incidents were not recorded for people in receipt of a service. We saw from people's records that when people had a fall neither an accident or incident form had been completed which would help ensure the registered manager had oversight of this. Records did not demonstrate what preventative measures had been put in place to prevent a re-occurrence and protect the person. This has been expanded on in the well-led section.

The above supports a breach of Regulation 12. Safe care and treatment. Health and Social Care Act (Regulated Activities) Regulation 2014

We asked people if they felt safe when being visited by carers. One person said, "Yes I do. I'm very satisfied." Another said, "Yes. I feel safe with them. It's a small group." Another confirmed they knew all the staff that visited them. We asked people if they knew who to contact if they had any concerns and they told us they did.

We reviewed recent safeguarding concerns which gave us confidence that the service was recording and reporting concerns as and when necessary. There was evidence that they cooperated with other agencies in terms of investigation. In a recent incident a person had missed medication and their health continued to decline until they were eventually admitted to hospital. This was referred to the safeguarding team and was subject to on-going investigations. Initial investigations were inconclusive as to the role medication had played in terms of their general decline. The registered manager told us they had a risk register in which they recorded information of concern. They said it enabled them to track thought anyone presenting with high, complex or changing needs. The register included a record of what actions they have taken to monitor the person's needs. As a result of this recent safeguarding notification staff supporting this person had completed a medication refresher course and had an assessment of competency to ensure they could administer medication safely.

Staff received regular and updated training to help them recognise potential abuse and actions they should take if they suspected a person to be at risk of harm or abuse. Staffs knowledge was checked from time to time through staff supervisions and meetings. Staff were expected to contact the office if they had identified any concerns. There were clear policies for staff to follow and these were referred to in the staff's handbook. For the people we visited an information file gave people contact details of whom to contact if they felt unsafe or if they had comments they wished to make about the service.

We looked at staff recruitment and found the service employed staff following an interview and in one of the two files seen checks had been carried out to test the person suitability for the role prior to employment. We only looked at two staff records and found the first one to be in order. It included satisfactory written references, an application form with evidence of previous employment and education, a disclosure and barring check which showed they did not have convictions which might make them unsuitable to work in care. There was also proof of their address, identification, right to work in the UK, and a valid driving licence and car insurance where they were a known driver. The other record contained all of the same information but the references were dated after the person was employed. It was not clear from the information provided if the person was on their induction and thus supervised or working unsupervised. We saw from an internal audit that concerns had been identified about staff records. The registered manager said they were currently working through them and bringing them all up to date. This included ensuring all certificates were current and renewing the disclosure and barring check every three years. We asked the registered manager to also review the records relating to staff interviews. This was because we found one set of interview notes to be very brief and did not illustrate how the person had demonstrated their knowledge for the role. It was also not dated or signed and the interview process had only been carried out by one staff member. It is good practice to have two to ensure the interview process is robust and fair.

Good

Is the service effective?

Our findings

People spoken with felt the staff were well trained. One person said, "Yes I do. They do their job well." Another said that the staff varied in their ability to wash their relative and that some could do with more training so that they could be more thorough.

Staff records provided us evidence of staff training which was mostly up to date or plans in place to update staff's knowledge. Training was a mixture of e-learning and practical training. The service had its own fully equipped training suite. Staff received training around the core competencies for their role but also specific training around peoples individual health care needs. Staff were supported on commencement of employment through a week long induction which consisted of practical training and familiarisation with the organisation and it policies. On completion of the staff induction new staff accompanied a more experienced member of staff out on care calls. This enabled them to meet people they would be supporting and observing what needed to be done for each person. An induction record showed what was covered as part of this induction and what the new carer had been observed as doing. This induction record helped to identify any further areas for development or training .The induction was differing lengths depending on the confidence and ability of the carer being inducted. A probationary period of three months was usual unless there were concerns about a person's performance in which case it could be extended. Staff told us their performance was reviewed at 4, 8 then 12 weeks. Records we reviewed for one person include 107 hours of shadowing.

The registered manager told us the company had invested in a new training programme which had been well received by staff and had opened up the range of courses staff could access according to the needs of the organisation and the interests of the individual staff. The service did not have staff within its team who were champions, i.e. had a specific area of knowledge or specialism where they could take the lead and share their knowledge with other staff. One member of staff had completed a more advanced course in dementia care but only covered one geographical area. Development of these roles would help to enhance the quality of the service. Staff were able to undertake further professional development as required and according to wishes of staff.

Records showed staff received regular supervision enabling them to discuss work related issues and their performance against company objectives. An annual appraisal was also provided. Spot checks were carried out to ensure staff were delivering care safely and following the correct procedures. Within the service there were different teams divided by geographical area. They were overseen by a team leader and had their own local staff meetings. However of late staff from different teams joined the meeting of another area and were able to disseminate information across to their team. This was a good idea as it helped ensure consistency across the whole service.

The Mental Capacity Act (MCA) 2005 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 reviewed this and found the service assessed people before providing a service to them. People were asked for their care preferences and asked to sign their consent for care to be provided to them. Some people told us that they had been asked if they would mind male/female carers and felt they had a choice about this. Information about this was recorded. If people lacked capacity to make specific decisions the registered manager told us that social services would be contacted and informed so a best interest decision could be taken. Staff were given training to help them recognise when people were unable to make informed decisions. They carried cards to help remind them of the principles of the Mental capacity Act.

We were given examples of when and how staff supported people who potentially lacked capacity. In one instance a person lost their wallet and although this was reported and dealt with as a safeguarding concern the person was confused about the chain of events and what had actually happened. This led staff to raise concerns about this person's capacity so this could be reviewed by the social worker. Another instance was a person who had accumulated lots of medicines and was getting confused about what they should be taking. This was picked up by the medication officer and not the carers. This resulted in a review of the person's capacity to take their own medicines and additional training for staff who should have identified this as a concern.

People's care plans established what support the carers should be providing. Staff were given training in line with people's care needs whenever possible such as dementia care, support with nutrition and any necessary medical input was provided by district nurses. The registered manager said they worked closely with other health care professionals but did not have any joint packages of support. Where carers were expected to support people with their medical needs advice was sought from medical professionals. Training and support was given around end of life care and whenever possible carers with relevant experience were matched with people using the service.

We saw from people's daily notes that changes in people's needs were recognised and followed up. For examples entries said 'discussed with daughter,' or 'informed GP.' Seniors told us the carers were very good at reporting any changes in a person's needs so these could be followed up.

Some people were supported to eat and drink in sufficient quantities where this was something that had been identified as the person requiring help with. Records of what people had drunk or consumed was recorded and monitored as far as reasonably applicable. We saw when visiting people that drinks were left for people in easy reach and simple meals were prepared. Shopping was purchased as required.

Good

Is the service caring?

Our findings

People gave us positive feedback about all the carers that visited them to help them with personal care and other daily tasks. All felt staff promoted their dignity and showed respect. A number of people said they had not always got on with the staff member caring for them but the service had responded to this and changed the carer. Most felt the service was reliable and they got good customer service. No one told us they felt rushed or uncared for. Everyone spoken with indicated that the care processes were consensual and nobody highlighted any issues/concerns in this area.

One person told us, "I think they are marvellous. I'm here by myself and I'd be lost without them. They're very kind, very helpful and respectful. They are polite and always on time. They'll do anything they can to help me. The things that they do, they're great. They'll really put themselves out for me. I would definitely recommend them based on my experience."

Another said, "I've had them for quite a few years'. I get them twice a week to help with bathing. I've got regular carers and I know them all by their first names. I would definitely recommend the service as they are very caring and respectful. I feel in control of things and they're lovely girls and they'll do anything they can to help." Another person told us, "They are all very nice, you wouldn't want to be bullied."

One person told us that carers would not leave until they knew they were okay. They gave the example of when they were unwell and they arranged extra support for them until they were feeling better. They said, "I trust them all."

Care plans gave us information about people's needs and life history. The information was relevant to the care provided. We only met one carer whilst visiting people and a visiting professional. Both were spoken highly of and were respectful towards the person they were supporting.

There was due regard for people's needs in relation to gender specific care, preferences and any other factors that should be considered when providing care such as the persons beliefs, values, race and religion. The registered manager said they did not operate in a particularly diverse community but were mindful of supporting people in the way they wished and knew how to access support and services as required. This helped ensure people's needs were met holistically. Information about equal opportunities featured in the literature we saw and this was reflected in the persons care records.

The registered manager told us a lot of their work had involved getting to know 'who was who' and engaging with the community about the support and resources they could provide to increase people's wellbeing. The Norfolk Directory is a resource for the community and the agency told people about this to help them navigate around the social care system. In addition the service was putting together information which was accessible to people and helped them live more independent and fulfilling lives. For example they arranged for a person who has some sight impairment to receive talking newspapers as this had been an important part of their daily routine and enabled them to remain informed regarding local and national topics.

The registered manager was exploring other possible partnership workings with local business and catering outlets who provide precooked meals for people. By increasing these relationships the registered manager hoped to increase people's awareness of what was available to them. The manager told us they had held several off site meetings for staff to attend, utilising local amenities, which they said had been welcomed by staff and strengthened their presence in the local community.

Increasingly the service was taking referrals for people approaching the end of their lives and they were able to put in comprehensive levels of support in line with need. The registered manager said staff were supported and comprehensive training was given to staff.

People were engaged in their care through the initial assessment of their needs and subsequent reviews of their needs. Periodically people were asked to complete a survey asking for their views of the agency but did not get feedback from this survey. There was not a newsletter and surveys had not been sent out this year. The previous year's survey received a high percentage of returns and generally a good level of satisfaction. People were given information about the service and who to contact should they want or need to and if they had any concerns. In addition people were signposted to other services and resources as and when appropriate.

Good

Is the service responsive?

Our findings

The service had a statement of purpose which told us about the service they provided. A service user guide was issued to people using the service alongside other information to help people know what to expect. The service provided a range of support including a sit in service, support with domestic duties and help with personal care.

Prior to offering a service a full assessment was undertaken and a care/support plan put into place within 72 hours of providing a service. Carers told us they had information about people's needs prior to providing a service. They told us support was provided flexibly according to people's identified needs. The team leaders told us they reviewed people at least three monthly after providing a service and then held an annual review of their care and documentation. In between times they held regular six monthly face to face or telephone reviews depending on the person's situation and ability to talk on the telephone. They stated they were planning to increase the level of contact with people to improve their performance and in line with the current monitoring and contractual agreement held with the Local Authority. Known changes in a person's needs such as hospital admission would also trigger a review.

We spoke with people about their experiences. One person said, "They're very kind and I'm very happy with them. I've gone from three visits down to one as I've been able to manage more myself. I would recommend them to someone else based on my experience."

People received the care and support they needed. One person said, "Yes. They are very familiar with how I like things to be done. One person told us how independent they were and tried to do as much for themselves. However they told us they looked forward to having the carers arrive and told us some of them were very interesting and they covered all sorts of topics. Their visits obviously increased this person's emotional wellbeing.

Care plans documented support and help needed at each visit. It gave in some instances personalised information about how the person wished to be supported with reference to their usual routines and preferences. For example open curtain, give them a cup of tea, and gently assist. Care plans were written in a way that promoted individualised care. The registered manager said they were changing care plans to make them more focused on outcomes. This means that the person is at the centre and the care plan identifies what's important to the person in terms of their treatment, care and quality of life. The plan would then state how this was going to be achieved and meant everyone involved in the persons support would work in a consistent way to ensure the person's needs were being met. Rather than describing a task to be achieved, the plan would describe the person and how they should be supported. Examples of how care and support was driven around the persons needs included a person who was unable to get out but wanted a haircut. Staff found and supported them to be visited by a mobile hairdresser. Another example was people wanting to make arrangements for their pets when they were not there to look after them. The service tried to source these things whenever possible.

While the care plans were comprehensive we felt more detail would be beneficial where people had

complex needs, communication difficulties such as aphasia where they might not be able to express their needs. We also felt care staff would benefit from more information about long term conditions people had and how this impacted on them on a day to day basis. Social and family history was collated but again this could be in more detail where the person was willing to give this sensitive information.

We noted that reviews were underway but some were overdue. This was being addressed through the recruitment and appointment of an additional team leader and an administrator. Whilst visiting someone we met a carer who quickly established a good rapport with the person and established what they were there to support them with. However we noted from the conversation that this particular carer had not supported this person for a number of months, and they did not check the persons care plan to see if their needs had changed. This could potentially result in the person not getting the care they needed. We spoke with one person who told us that new staff would ask them what to do rather than necessarily looking at the care plan.

The service had a complaints procedure and this was clearly publicised so people knew how and who to raise any concerns or compliments they might have about the service. They were advised of who they could contact outside the immediate organisation if they felt this necessary. We saw examples of actions taken as a result of feedback which demonstrated that the service took into account people's feedback.

Requires Improvement

Is the service well-led?

Our findings

The service was mostly well led but we identified a number of concerns and a breach which could impact on the safety and well-being of people using the service. People could not always be assured that changes were made to improve the service as a result of accidents and incidents. Accidents and incidents were not analysed and learnt from. There were a number of people who had sustained falls but no investigation had been conducted into these and no action had been taken as a result, such as care plans and risk assessments being reviewed and updated. The current system to assess, monitor and improve quality and safety of the services provided was not effective to ensure people's needs were properly monitored and reviewed, to inform their care planning. We found this had not impacted people's safety however was an area for improvement.

Risks relating not only to the person's care but also from the environment the care was provided in was considered and documented. We found information relied on mainly yes or no responses with not much detail to inform staff of either the risk or its severity. It was not clear from the risk assessment if actions taken to reduce risk were effective. A generic approach to completing documentation did not support an individualised approach to care. We found some of the documentation a little contradictory. For example some questions required a yes or no and we found both answers ticked so did not know which one was accurate. We also saw some information was a little disjointed. For example one person on their assessment of risk recorded they had no skin problems but on their medication record it stated they had an ulcerated leg which was being treated by the District nurse. This could lead to some confusion.

People spoken with told us they were satisfied with the service they received. One person said, "Yes I am. I feel comfortable and confident with the service." Another said, "Yes I am. Everything I've asked for I've got. "People told us either they would recommend the service or would not want another service.

The registered manager had been in post for about a year and was registered with the Care Quality Commission as required. They were extremely knowledgeable and were clear about what they had already achieved and what improvements they wanted to make. All the staff spoken with were confident in their abilities and found them visible and approachable. Senior staff told us they were able to work with a degree of autonomy but had support when they needed it and felt the registered manager listened and dealt with their concerns effectively. They told us there had been three managers in six years and a lot of changes to the service delivery model. The registered manager said there had been changes to the contractual obligation with Norfolk County Council and a reduction in work. Staff felt at no time was the standard of care affected. Staff said the registered manager was good at consulting about proposed changes and engaging staff in the decision making processes. Staff felt things were settling down but very busy and there were not always enough staff to realistically do everything they needed to. They said some staff having left had returned again because they realised it is a good service.

The staff worked from an open plan office and were observed as working hard ensuring calls were answered promptly and information disseminated effectively within the team and with the carers delivering the care. Senior staff had clearly defined responsibilities but it was clear that some geographical areas had high levels

of demand which was difficult to adequately cover at times of unplanned staff sickness and higher levels of annual leave, (such as summer holidays.) The registered manager said improvements had been made in terms of call times, with less missed calls in recent times. The registered manager told us they had developed an emergency, contingency plan which considered factors which might affect the care delivery such as adverse weather. In this instance the registered manager said they could access different transport links to get care staff to where they needed to be. They were also looking to invest in an electronic monitoring system which should help to monitor the service being delivered more effectively.

The registered manager was engaged in active recruitment and trying to improve retention of existing staff so the business could grow successfully and meet its commitments. They performance managed staff and when appropriate carried out return to work interviews, performance interviews and exit interviews when staff left the service. This helped build up a picture of what was working well and not so well. The linking of residential and domiciliary services offered flexibility by increasing the pool of staff if managed well. The registered manager explained the stability of staffing had been affected by a period of restructuring but now felt this had stabilised, retention had improved and they had a committed staff team in place.

As a response to our inspection the registered manager updated their procedures in relation to data protection and ensured as far as reasonably possible that confidential information was held safely. This helped to protect people's confidentiality.

Surveys were one means of the service gaining feedback about the service. This helped them to plan the service in terms of people's experiences and know where improvements were required. We saw the previous year's surveys which had been widely circulated and had yielded a good response. They showed high levels of satisfaction with the service. At the time of our latest inspection surveys had not been circulated but were immediately following our recent inspection. Surveys were also sent out to staff to gauge their level of job satisfaction and if they had any concerns about their working practices. This gave the organisation an opportunity to recognise any factors affecting staffs wellbeing. The registered manager told us and we saw evidence of regular reviews and consultation with people using the service. There were also local forums for people using services to have their say

The registered manager relocated to Norfolk prior to taking up employment here. They have developed links into the local community and formed alliances with other partner agencies, attending local forums and building relationships with other social and health care professionals. This kept their knowledge up to date but also enabled them to understand the landscape of social care and what was available for the good of people they were supporting.

We found staff had the necessary skills and there were good systems in place to induct, support and skill up their work force. Everyone we spoke with were comfortable with the staff supporting them and we found systems in place to improve staff practice and support their development. The registered manager told us additional resource has been provided to the branch and more laptops and computers to help ensure staff could access their on-line training within the office environment. They said this had helped to promote communication with staff and provided additional resource for business continuity and out of hour's management.

We found care plans contained an adequate level of detail but agreed these could be more personalised to the individual needs of the person using the service. The service confirmed the care plan format was currently under review and this involved senior care staff and representatives.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment There were systems in place to help ensure people received their medicines as intended however these were not always effective in identifying errors in a timely way. This had the potential of putting people at risk of avoidable harm. Records around the management of risk required improvement to clearly show how risk was being effectively monitored and managed.