Midland Care Services Limited

Swift House

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Swift House is a domiciliary care agency which provides personal care support to people in their own homes. At the time of our visit the agency supported around 150 people with personal care.

We visited the offices of Swift House on 1 August 2016. We told the provider we were coming before the visit so they could arrange for staff to be available to talk with us about the service. There was a management team based in the office that organised the scheduling of calls, staff training and recruitment.

The service has a registered manager but at the time of our visit they were on a period of extended leave. 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. At the time of our visit the assistant manager/finance manager who was also the registered 'nominated individual' for Swift House was managing the home. They are referred to in this report as the 'registered person.'

People felt safe using the service and care staff understood their responsibilities to protect people from abuse and keep people safe. There were procedures to manage identified risks with people's care although there were some risk assessments that had not been developed, which the registered person agreed to address. People told us they received their medicines as required.

Recruitment checks were carried out for new staff to make sure they were suitable to work with people who used the service. There were enough staff to deliver the care and support people required and most people were positive about the staff. They said staff had the right skills to provide the care and support they required and they stayed long enough to complete the care they required.

The provider and registered person understood the principles of the Mental Capacity Act (MCA). Care staff were to complete training to develop an increased knowledge and understanding of the MCA. Care staff knew to gain people's consent before they provided personal care.

Staff received an induction when they started working for the service and completed training to support them in meeting people's needs safely and effectively.

Care plans contained information for staff to help them provide the personalised care people required. People knew how to complain and said that the management team based in the office were helpful in resolving concerns. Care staff said they could raise any concerns or issues with the management team knowing they would be listened to and acted on.

We found that whilst staff were responsive to people's needs, some people experienced calls outside of their agreed times and received support from an inconsistent group of care staff.

There were processes to monitor the quality of the service provided and understand the experiences of people who used the service. However, we could not always see that information collected resulted in lessons being learned and improvements to the service.

Audit processes did not consistently identify that records were not always up-to-date and accurate. This included the Statement of Purpose and complaints records. We also found that sometimes actions were not identified and addressed. This included reporting safeguarding information to us as required.

Staff felt supported by the provider and the management team and most were positive about their experiences of working for Swift House.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

There were procedures to protect people from the risk of harm. Staff understood their responsibility to keep people safe and to report any suspected abuse. There were enough staff to provide the support people required and people were supported safely to take prescribed medicines where required. There were procedures for managing risks related to people's care and a recruitment process that ensured checks were carried out to ensure staff were suitable to work with people.

Is the service effective?

Good

The service was effective.

Staff completed training to ensure they had the knowledge and skills to deliver safe and effective care to people. The registered person understood the principles of the Mental Capacity Act 2005 and care staff ensured they gained people's consent before delivering care.

Is the service caring?

Good

The service was caring.

People described staff as being caring and supportive. Staff ensured they respected people's privacy and dignity, and promoted their independence. People received care and support from staff that understood their needs.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's care needs were assessed so that they could receive a service that was based on their personal preferences. Most people had a consistent group of staff that supported them and received care as expected. Some did not experience this. Staff understood people's individual needs and were kept up to date about changes in people's care. People knew how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Most people were satisfied with the service they received. Staff felt well supported by the management team and registered person. Staff understood their role and responsibilities and received support and supervision to carry out their work safely and effectively. Some processes and systems to support the quality of the service were in need of improvement.

Swift House

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Before the inspection, we reviewed all the information we held about the provider. This included information shared with us from the Local Authority and statutory notifications received from the provider. A statutory notification is information about important events which the provider is required to send to us by law.

We did not ask the provider to complete a Provider Information Return (PIR) prior to this inspection. The PIR 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 did not request this form because the inspection date was brought forward in response to information we had received about the service.

The office visit took place on 1 August 2016 and was announced. We gave the provider 48 hours' notice we would be coming so they could ensure they would be available to speak with us and arrange for us to speak with staff. The inspection was conducted by two inspectors 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 office visit we spoke with 21 people or their relatives by telephone. During our visit we spoke with five care staff, the registered person and office based staff. The office based staff included the care co-ordinators for South and East, head of senior care staff, a senior care staff member and a staff member responsible for recruitment and training.

We reviewed four people's care plans to see how their care and support was planned and delivered. We checked whether staff had been recruited safely and were trained to deliver the care and support people required. We looked at other records related to people's care and how the service operated including the services' quality assurance audits.

Good

Is the service safe?

Our findings

People we spoke with said they felt safe with the staff that supported them. They told us they had built up trust with staff which made them feel safe. One person told us, "More than happy with [staff member] ….would trust her with anything." Another told us "[Staff member] is marvellous….. I would trust her completely." People told us they felt confident to contact the staff based in the office if they were concerned about anything.

Staff completed training in safeguarding adults and knew about the different types of abuse and their responsibilities to report any concerns to their manager. One staff member told us, "I would contact the office and make sure the office are aware… make sure the client is ok and speak to them." Another said, "If a client has bruises, contact the office straight away. We have to fill out a report." One staff member told us about how one person had gone outside their house and had accidentally let the door to the house close and had not been able to get back in. They told us how they had swiftly acted to contact a family member, had contacted the office and had supported the person until they had been able to get back in. This showed staff understood their responsibilities to keep people safe.

The registered person told us about safeguarding referrals that had been made to the Local Authority when people had been placed at risk. They told us the actions that had been taken to address the risks to ensure people were kept safe. These had not been reported to us as required and they told us this would be done in future.

There was a procedure to identify and manage risks associated with people's care, such as environmental risks in the home or health risks such as poor mobility. These assessments helped to keep people and staff safe when delivering care. Risk assessments were completed prior to people receiving a service and people were asked about their care needs so that risks could be fully assessed. If the referral for home support was urgent, a risk assessment was completed by a senior staff member at the first home call. All staff had been trained to assess risks to people on each call. Any changes in risks, staff referred to the office so that a member of management team could carry out a re-assessment. A member of the management team told us, "Staff continually risk assess on each call, they would look at the environment to make sure it remains safe to work in and for the service user to move around and assess the person to make sure they are well." We noted that risk assessments had not been completed for the use of bedrails to ensure people were kept safe. The registered person told us this would be addressed. We did not identify any concerns relating to people's experience of bedrail use during our inspection.

Staff knew about the risks associated with people's care and were able to explain how these were to be managed. For example, a staff member told us about one person who was not walking correctly with their walking frame which presented them with a risk of falling or back problems. They told us, "If I go on a regular basis I can see if they are not using the 'Zimmer' (walking frame) or trolley properly. [Person] stands back about three or four foot away. I had to adjust it... they said how much better it is. [Person] is now standing up right" Another staff member told us how they knew to report any red or sore areas on people's skin to the management team to make sure processes were put in place to manage any potential risks of further

skin damage. They said the office staff would "ring the nurses." A member of the management team told us 'tissue viability awareness' (skin care) was discussed during staff induction training and staff were shown pictures of different stages of pressure ulcers and told what they are expected to do in response to these.

Staff completed training in moving and handling people so they could assist people to move around safely. People and relatives told us staff knew how to support people in a safe way. One relative explained their family member needed a hoist to move them. They told us, "[Person] needs a hoist to lift them in and out of bed" and when asked if they used this safely, said, "Yes very much so. Not had a problem."

Care plans provided detailed information about risks to people and how staff should manage them to keep them safe. For example, one care plan stated a person used oxygen; there were clear instructions about how the person needed to be moved to ensure their oxygen supply was not interrupted.

Staffing arrangements ensured there were enough staff to complete calls to people. The registered person said there were enough care staff to allocate all calls people required. From talking with people and viewing staff schedules we found this was the case. However, calls were not always being made by regular staff and people told us there had been instances when a call had been missed. The registered person told us, "We do get a couple inevitably. It is because they have not been scheduled." They explained that sometimes extra calls were allocated to staff if regular care staff were on holiday or sick and office error had resulted in the calls not being allocated. However, we were told this was a rare occurrence. The registered person told us when this did happen she spoke with the staff member concerned to ensure it did not happen again. When we looked at the most recent staff call schedules, there had been no recent missed calls.

The provider had an out of hour's on-call system when the office was closed. There was an 'out of hours' telephone number that people could use if for any reason care staff did not arrive for calls. The registered person told us when this happened they were able to make arrangements for other staff to complete calls if needed to ensure people's needs were met.

We looked at how medicines were managed. Most people we spoke with administered their own medicines or their relatives helped them with this. People who were supported with medicines told us they received them as required and had no concerns about how their medicines were managed. One person told us, "[Staff member] is marvellous. She helps with washing and does all my tablets and medicines." Another said, "They make sure I have taken my tablets and also get them ready for me."

Staff said they felt confident to administer medicines and told us they always checked the records to make sure the staff member before them had signed the records to confirm medicines given. We asked a staff member what they would do if they saw a gap on the medicine administration record that could suggest the medicine had not been given. They told us, "It's very rare I have seen gaps. We had a big meeting about that to make sure everything is filled in." Staff told us they reported any concerns they had to the management team in the office. Medicine administration records we viewed showed people had received their medicines as required. However, instructions in one care plan we viewed were not clear if staff were to 'prompt' or 'administer' the person's medicines. This was important to ensure staff were clear on their responsibilities. This was brought to the attention of the registered person so the information about medicines could be reviewed.

Recruitment procedures ensured staff were safe to work with people who used the service. A member of the management team said staff did not work independently until all checks were in place. They told us, "All staff have a Disclosure and Barring Service (DBS) returned before they are allocated calls." The DBS assists

employers by checking people's backgrounds to prevent unsuitable people from working with people who use services. Staff said they could not work unsupervised in people's homes until their disclosure and barring certificates had been returned. Records confirmed staff had DBS and reference checks completed before they started work with the exception of one file viewed where this was not clear. However a member of the management team was able to confirm these checks were in place.

Good

Is the service effective?

Our findings

People and their relatives told us they thought staff had the skills necessary to support people's needs. We found training processes and staff support systems were effective and helped to ensure people received safe and effective care.

A member of the management team told us care staff completed essential training and new staff who had not worked in a care environment before completed training linked to the Care Certificate. The Care Certificate sets the standard for the skills and knowledge expected from staff within a care environment. Staff confirmed they completed an induction to the service when they first started work that prepared them for their role. The induction training included staff attending face to face presentations supported by the use of DVD's, and questions at the end of the training to check their learning. Experienced care staff completed 'top up' training during their induction to confirm they had the skills required to carry out their role.

A member of the management team told us, "New care workers don't do care calls on their own until they have completed their induction training and shadow shifts. This can take four to six weeks depending on the individual. After shadow shifts, initially they are allocated double up calls so they work with an experienced carer." They also told us they completed 'first call follow up' calls. These involved speaking to both the staff member and the person who received the care to make sure there had been no problems.

We saw on-going training was provided following the induction training to ensure staff maintained their skills. A member of the management team told us, "Updates in training have to be completed before the expiry date. The system will alert you when staff need to update their training." Staff had attained, a National Vocational Qualification (NVQ) in care or were working towards attaining a QCF (Qualification and Credit Framework) in care. This was to help them further develop their skills and knowledge to effectively meet people's needs.

A member of the management team explained how they ensured staff had the right skills to support people. They told us, "Each staff member is entered on to the system. Information for staff includes the training they have completed so we can match new clients to staff skills."

Staff had received limited training in regards to specific health conditions such as dementia, diabetes and Parkinson's disease to help support them in their role. However staff had some knowledge of these conditions. One staff member told us how they supported a person with diabetes and were aware of the risks this condition could present and how to manage them. They explained how the person was eating too many sugary foods and it was impacting on their health and how they presented. They told us how they had contacted the family about this who had taken action to provide less sugary foods. This had resulted in the person being much calmer and less at risk of ill health.

The registered person told us, "We go through dementia and things with them. We have discussions with family members. Carers would do 'dementia awareness' (training) if they are going to support someone with dementia."

The registered person told us that staff supervision meetings took place every three months and included 'spot' checks where staff were observed during calls to ensure they were following the policies and procedures the provider expected. Appraisals were completed once a year where staff were required to completed a questionnaire about their work. This helped to identify any areas for staff development.

Care staff confirmed their knowledge and learning was monitored through supervision meetings and unannounced 'observation checks' of their practice. One staff member told us how supervision meetings had helped them to increase their hours. They told us, "You can put your word across if you have a problem with anything. At first I didn't have enough hours and since then I have had increased hours." Another staff member told us how following their induction they had regular 'spot' checks to check their competence and that they were working safely, they told us, "I had regular spot checks. They (manager's) checked if I was wearing my uniform and was handling people properly." We asked what happened if they were not, they told us, "They will say [staff member], you are not doing this right and mark it down on sheet. If you forgot how to do it, you are brought back in for further training."

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

People can only be deprived of their liberty to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS).

Care staff were not clear in their understanding of the MCA and the registered person told us training was imminently planned. Staff told us if they had any concerns about people's capacity they would contact the management team based in the office.

The registered person had a good understanding of their responsibilities under the Act. They told us, "We had a couple of clients assessed under the MCA although we have not assessed them ourselves. We have regular case conferences for both individuals these include professionals from all sectors including district nurses, doctors.… If we suspect a service user lacks capacity, we report this to social services or family and the doctors." They went on to tell us about a person who lacked capacity who had been harming themselves. They had worked with social services and health professionals to help keep this person safe.

We asked staff how they knew people consented to care, they told us they asked people before delivering care which demonstrated they were aware they needed to do this. One staff member told us, "By asking them if they are happy with me doing a wash or providing food."

When people were assessed, the arrangements for food preparation or support were discussed and agreed. Most people told us they had microwave meals delivered and some said they had fresh food prepared by staff. People said they were provided with meals and drinks of their choice. People told us, "I select my own (meals) and they sometimes prepare for me what I fancy" and "I have microwave food and they always get it for me" and "They always see I have enough, they always make me a drink." Staff confirmed they supported some people with meals and always ensured they were offered a choice. One staff member who completed morning calls told us, "I always ask them what they want for breakfast."

Some people were at risk of poor nutrition due to consuming limited amounts of food and fluids. The registered person told us in these cases they had introduced food and fluid 'intake' charts for staff to complete to help them monitor how much they were eating and drinking to help ensure they were not placed at further risk of deteriorating health. The registered person told us, "If we suspect malnutrition or dehydration it is referred to doctors, district nurses and in some cases paramedics which often results in a hospital admission. Our charts are monitored by family and medical professionals and we take instruction from them." They went on to explain that one person monitored by them had not been eating and drinking enough and due to this being identified promptly by staff, this resulted in the person being admitted to hospital to ensure their healthcare needs were met. This demonstrated staff understood the risks associated with nutrition and had taken the necessary action to address them.

People were supported to manage their health conditions and had access to health professionals when required. Most people we spoke with managed their own health care appointments but some said staff helped them with this. Staff confirmed they supported people when required. One staff member told us, "We assist them as much as we can, we will help them if they need us to call GPs and district nurses."

Good

Is the service caring?

Our findings

People described staff as being caring. People told us they were involved in making decisions about their care and were able to ask staff for what they wanted. They told us, "[Person] helps me get showered and ready for the day. She cares and is excellent" and "[Person] is so caring. I wouldn't want to lose her. She does everything I ask." A relative told us, "On the whole whoever comes are caring. They have a difficult job but they take time with [person] to ensure [person] is ok."

People confirmed they were involved in making decisions about some aspects of their care and were able to ask care staff for what they wanted. Care plans reflected decisions made during the assessment and planning process.

People usually had a consistent group of staff that supported them and people told us they were happy with their regular staff group. On occasions some people had a high number of staff that supported them. This was because some staff worked part time which meant more staff were needed to cover each full week. For example, some people had a regular group of staff for four days of the week and another regular group of staff for the following three days of the week. Sometimes if regular staff were off sick or on holidays other staff supported people. When this happened people told us they did not like it. Comments included, "I like my regular carer but different ones come on weekends" and "I would like a regular carer for consistency." The registered person told us they were always recruiting staff with the intention of employing full time staff to help increase consistency but this was not always possible.

People told us staff made sure their privacy and dignity was respected when supporting them with personal care. This included keeping shower curtains closed and checking if they wanted family members to leave the room. Staff explained how they maintained people's privacy, dignity and independence. One staff member told us, "Most of them like to wash their own hands and face and I do their back and underarms, I always put a towel over them….. They choose what they want to wear… I say 'Do you want to wear a skirt or trousers?' and they sit and like to talk to me."

Staff described how they built relationships with people to help them care for people in ways they preferred. One staff member told us, "I like to talk to people when I go in….always willing to help." Another staff member explained their approach to people, they told us, "Be nice and kind and ask how their day has been. When you get to know them you know their sense of humour."

Staff described how when they supported people with care they did the little things that made a difference to them. For example, making sure people were positioned in bed correctly so they were safe and comfortable. One staff member explained how one person tended to lean to one side when in bed so they ensured they were supported with a pillow on that side. Staff told us if they were on a call and the person needed additional support due to deteriorating health they would not leave them but phone the office and tell them they needed extra time. This was so the next person could be contacted and advised they may be late.

The registered person explained how the provider expected staff to get to know the people they supported to help staff meet their needs effectively. They told us, "Staff are supposed to read the care plan and I expect them to get a bit of rapport so they can build up a relationship with them (people). You can tell that some carers will get on better with some clients."

We observed that staff in the office had a caring approach when speaking with people on the telephone. We received positive comments from staff and people who had called the management team in the office. Staff explained that if they ever had a problem, they could discuss it with the registered person and they helped them whether this was a personal or work problem.

Requires Improvement

Is the service responsive?

Our findings

People told us their needs had been assessed before they started to use the agency so that staff knew what support they required. During the assessment, information was collected on people's personal care routines to help in the development of a 'person centred' care plan for staff to follow. Information collected included personal information about people's background, their family, work background and hobbies. This helped staff to communicate with people, about items of interest to them, until they got to know them.

Some people felt that staff knew their needs well. One person told us, "My carer knows what I like and what to give me." Relative's also commented that staff knew their family members needs well. One told us, [Staff member] always spends time with [person] and they talk as well. [Staff member] knows all [person's] needs."

Staff had good understanding of people's care and support needs for those people they supported regularly. They knew about their individual needs and described how they provided care in a way they preferred. When staff carried out calls to people they were less familiar with, their knowledge of people's preferences was limited which meant they relied on care plans to assist them in meeting the person's needs. Staff said there was detailed information in care plans to inform them what to do on each call. If people's needs changed, they referred the changes to the management team so plans could be updated. Staff told us plans were up-to-date and reviewed regularly so they continued to have the required information to meet people's needs.

People confirmed they had care plans in their homes that staff used and which were reviewed with them to make sure their needs continued to be met. We looked at four people's care records to see how people's needs were identified and supported. Care plans contained instructions about what staff were expected to do at each call to support people. We checked one person's care records to see if the advice provided by a nurse regarding skin management had been transferred into their care plan. We saw this had been done. This was in relation to the risks of their skin breaking down and them developing pressure sores. However, we noted records stated, "to check body for sores" as opposed to staff checking if there were any red areas or changes in skin which could lead to pressure sores. Early intervention can prevent sores developing. We advised the registered person of this so that they could review this information.

When we looked at another person's care plan we saw this contained person centred information such as how they liked their breakfast to be prepared and how they usually spent their day. Staff who supported this person told us they were very independent and liked to do as much as they could for themselves. They explained to us how they encouraged the person's independence to support their wellbeing. A staff member told us that this person sometimes developed sore areas on their skin. They told us when this happened they reported it to their family member and also informed the district nurse to make sure this was addressed. They also told us they applied a prescribed cream to the person's skin to prevent further skin damage. This demonstrated that they responded the person's needs effectively.

We had identified from information shared with us prior to our visit that some people had not received calls

within the times they expected to meet their needs. Some people told us weekends could be a particular problem and they felt staff sometimes rushed their care. Comments included, "They have chopped and changed over last six weeks. Apparently some don't turn in for work" and "Weekends can be a problem. I don't have my regular one. Sometimes they are in a rush" and "At weekends they sometimes rush and can't wait to go."

One person told us when they could not receive support from their regular staff member they would cancel their calls as they would rather not receive support from anyone else. They told us they had encountered a negative experience when being supported by a different staff member.

A member of the management team told us, "Calls to people are allocated to the South or East area. We know in advance from social services how many calls people require, the duration of the call, the preferred time and how many care workers are required." They explained that some staff worked 16 hours a week which caused some difficulty in scheduling calls so that people had the same staff but they explained that 80 per cent of the people they supported had regular staff.

We asked staff if they were ever late for calls, they told us they were usually on time. One staff member told us, "Nine out of ten times, its only five minutes late. I always apologise to the next person. Sometimes I let them know in advance as they will worry, we have their numbers. I can ring the next client myself or I will ring 'on call' (management staff) and to tell them I will be late."

When we looked at the call schedules we found that most people received their calls from staff within the timeframes agreed. However, there were some people not supported at the times they expected. For example, one person had a call scheduled in July 2016 for 21.30, the staff time sheets indicated the staff member should carry out the call at 21.30 but the actual time the person received the call was 19.15 – two hours earlier than expected. On other dates we saw calls were carried out earlier than expected. These ranged from one hour up to one and a half hours early. A second person whose records we viewed also received calls an hour or hour and half early. We were told there was an agreement that care staff could arrive 30 minutes either side of the agreed times. Records showed occasions when some people were not supported at the times they expected or agreed. This did not promote person centred or consistent care that was responsive to people's needs and wishes.

People told us staff usually stayed long enough to do everything that was required of them before they left but there was the odd occasion when staff could be late. On these occasions some people told us their care was rushed and they did not find this a positive experience. Comments included, "Can be rushed if running late….the odd one rushes me" and "More or less on time. Sometimes a few minutes late but calls are long enough and never rushed."

People knew who to speak with if they had any concerns or complaints about their care and most felt their views were listened to and acted upon. People told us, "If I've got anything to say, I tell the carer. I can also speak to a senior one," and "I always phone the office." One person told us, "I spoke to the girls in the office. They are always nice and get it sorted." Another told us, "I had one issue when we joined but I spoke to the manager and it was sorted out."

We looked at how complaints were managed by the provider. The registered person told us, "They (people) should have a complaints procedure in their file sent out to them. The senior would go through that with them." However, the complaints procedure seen did not contain the contact names and telephone numbers of senior staff within the organisation that people could approach. There were also no details of how to pursue a complaint with the Local Authority and who to contact. This was brought to the attention

of the registered person.

We looked at complaints received by the provider and saw actions had been taken to respond to those received in a timely manner. However prior to our inspection, we had received a complaint from a person who had not been happy with the way their concerns had been managed. They told us there had been delays in their calls being returned which had resulted in them writing a complaint suggesting the complaints process may not have been fully effective for them.

Requires Improvement

Is the service well-led?

Our findings

Overall people spoke of being happy with the care and support they received. They used the words "reasonably" or "pretty" happy to describe their experience of the service. Typical comments included, "Generally ok, pretty good on the whole" and "Happy with the service." Overall, we found there were some areas needing improvement to ensure people always received a person centred service that was in accordance with their needs and preferences.

The provider aimed to provide a person centred service where people felt at ease to contact the management team based in the office if they were not happy about anything. People told us they knew who to contact if they were not happy and if they needed support to ensure their needs were met.

People spoken with commented they were satisfied with the service when they had regular staff supporting them but the quality of the service changed when they had different staff. They mentioned that the weekend service sometimes was not as good. Some people had calls much earlier than they should. This had not been identified by office staff when timesheets or records of calls had been returned to the office. A staff member confirmed that when changes to regular staff were made this did impact negatively on people. They told us, "When they send in someone different, that is when we have the problems."

To help ensure people received a consistent quality of service, the provider and manager's used a range of quality checks to make sure the service was meeting people's needs. Records confirmed people were asked for their opinions of the service through spot checks, telephone calls, care plan reviews and satisfaction surveys. We looked at a sample of returned surveys from people or their relatives, the responses and comments were mainly positive. However, quality audits used to monitor the quality of service were not always fully effective in ensuring follow up actions were taken to drive improvement of the service. For example, in one person's care file there was a quality audit that identified there had been "missed calls sometimes" but in the action section it stated "no action required". This action did not ensure the issue was addressed for the person or acknowledge the risks associated with missed calls.

Risk assessments were not always in place and management audit processes had not been effective in identifying this. For example, we noted there were not always clear instructions about how staff should respond to sore or red areas identified on people's skin. When we looked at daily records of calls for one person at risk of developing sore areas, they did not demonstrate pressure area checks had been carried out. Where people were at risk of skin damage, this was important to make sure staff took the necessary actions to support the person and prevent further skin damage and ill health. In other care plans bed rail risk assessments had not been completed to demonstrate the safe use of rails to avoid injury and entrapment.

Medicines competency assessments were not carried out to ensure staff continued to manage people's medicines effectively following training. The registered person said they would implement this and devised a form to do this during our visit.

Accident and incident records were completed but we found there were some safeguarding issues detailed in these records that had not reported to us as required. This meant we had not been able to check they had been sufficiently managed at the time to manage risks and ensure the safety of people. The registered person told us this would be addressed in the future.

We viewed the Statement of Purpose (SOP) for the service. A statement of purpose should describe what the provider does, how and where they do it and who they do it for. The SOP should contain information about the aims and objectives of the service and is an important document for staff to know about and work to. We found this contained out of date information which meant staff could not rely on information this contained being accurate. We saw the complaints policy was also in need of updating to ensure it included all of the information necessary to support people in making a formal complaint.

Staff felt valued by the provider and told us they were supported by the management team. They said the management team was approachable if they wished to raise any concerns. One staff member told us, "If I have an issue, I bring it up straight away and it gets sorted." Another staff member told us, "Yes they do support me very well… If I am not happy with something I will say. If I need something, they do support me. [Registered person] is here all of the time. I can pick the phone up any time to talk to [Registered person]."

Staff told us they enjoyed working for the service and felt it was well managed. One staff member described the service as "Efficient and reliable" and went on to say, "I have never had any problems." Other staff told us, "I love it" and "I think they look after the carer's quite well." Staff told us they attended staff meetings where they could talk about issues linked to the service. This helped staff to keep up-to-date on quality issues and what was happening within the service. One staff member told us, "We usually have a sheet with subject on like time keeping and [Registered person] will run through them and if we have any input, we will raise any concerns we have at that time." It was not clear from the notes of the meetings that actions stated had been carried out to demonstrate improvement.

The registered person told us how staff meetings were important for staff to get together and share their experiences and talk about the service. They commented, "We try to have staff meetings every three months maybe six. The last one was two weeks ago because they need to be able to see me and air their views. When they are all together they give advice to each other."