North Tyneside Home Care Associates Limited

North Tyneside Home Care Associates Limited

Inspection report

Town Mission
Lower Rudyerd Street
North Shields
NE29 6NG
Tel: 0191 257 5449
Website: www.northtynesidehomecare.co.uk

Date of inspection visit: 19, 21, 22 and 27 May 2015
Date of publication: 14/08/2015

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

Overall summary

The announced inspection took place on 19, 21, 22 and 27 May 2015. We last inspected the service in March 2014 when we found the service was meeting all the regulations that we inspected.

At the time of our inspection, North Tyneside Home Care Associates Limited provided home care and housing support for 260 adults living in their own homes within the North Tyneside area. These figures will fluctuate due to the nature of the service. The service is part of a larger employee owned domiciliary provider spread across mostly the North of England known as CASA (Care & Share Associated Limited) and the service is locally known as CASA.

The service had a registered manager in post. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

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.

We considered people were not fully protected against the risks associated with medicines because associated care plans and risk assessments were not always in place and reviewed regularly. We also found people's care records in need of further improvements.

The provider had dealt with previous safeguarding concerns appropriately. There were safeguarding policies and procedures in place. Staff knew what actions they would take if abuse was suspected.

Accidents and incidents were recorded and monitored by the registered manager and the provider to help them identify any trends. We saw that accidents had been recorded and dealt with appropriately.

The registered manager told us they tried to ensure people were visited by the same care staff but that was not always possible due to sickness or holidays. Staffing levels were maintained by timely and safe recruitment procedures.

Staff had received an induction and completed a programme of training. Staff said they felt supported by their line manager and the provider.

The registered manager was fully aware of the Mental Capacity Act 2005, particularly in relation to the court of protection There were policies and procedures in place and staff had been trained.

People were provided with meals and drinks they had chosen and preferred if that was part of their identified need.

People were treated with respect and dignity and staff were kind and considerate.

A complaints procedure was in place and people and their relatives knew how to access it and who they needed to talk to should this be required.

The service had a management team in place. Expertise was used in the service from the clinical lead for example when this was required.

We found one breach in relation to Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. This related to record keeping and governance. You can see what action we told the provider to take at the back of the full version of this report.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

People were not fully protected against the risks associated with medicines because associated care plans and risk assessments were not always detailed or reviewed. Some other risk assessments were not always in place or regularly reviewed.

People's finances were found to be in order, but records needed to be improved.

Safeguarding policies and procedures were in place and staff were aware what actions they would take if abuse was suspected.

Staffing levels were maintained and safe recruitment procedures were followed.

Is the service effective?

Good

The service was effective.

Staff had received induction and on-going training to support them to meet the needs of the people they cared for.

People received food and drink which they were happy with.

The registered manager was aware of the Mental Capacity Act 2005, particularly in relation to the court of protection.

When additional support from other healthcare professionals was required, staff supported people with this.

Is the service caring?

Good

The service was caring.

Staff were very good at talking to people and reassuring them.

People were treated with respect and their dignity was maintained.

Where people had particular religious needs, staff respected this and acted appropriately.

Is the service responsive?

Requires Improvement

The service was not always responsive.

People's needs had been assessed but care plans were not always in place, detailed and reviewed regularly.

When people had an activity as part of their care package, they were encouraged with this.

Summary of findings

Complaints had reduced over the past year and any received had been dealt with effectively.

Is the service well-led?

Requires Improvement

The service was mostly well led.

There was a registered manager in place who was committed to providing a good quality service to the people she worked for.

The registered manager and provider completed a range of audits to monitor the quality of the service but further work was required to action issues outstanding.

Surveys were sent out and analysed to assist the provider with improving the quality of care.

North Tyneside Home Care Associates Limited

Detailed findings

Background to this inspection

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

This inspection took place on 19, 21, 22 and 27 May 2015 and was announced. The provider was given 48 hour's notice because the location provides a domiciliary care service and we needed to be sure that someone would be present at the service offices. The inspection was carried out by two inspectors and one 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, 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 information we held about the service, including any notifications we had received from the provider about serious injuries, deaths or safeguarding concerns. Prior to the inspection we contacted the local authority contract team and safeguarding officers. We also contacted the local Healthwatch organisation by email to obtain their opinion of the service. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England. We used their comments to support our planning of the inspection.

We contacted health and social care professionals by telephone before and following the inspection to seek their opinion of the service. These included community nurses, social workers, occupational therapists and speech and language therapists.

We visited 16 people in their own homes and spoke with 22 by telephone. We also spoke with five relatives.

We spoke with a number of staff during the inspection, including the registered manager, managing director, regional manager, regional clinical lead, compliance and quality director, operations manager, team manager, two coordinators, one supervisor, the office administrator, the human resource officer and 13 care staff.

We looked at a range of care records which included the care records of the people we visited in their homes (16). We also checked the personnel files of 12 staff members. We looked at accident and incident records, training records, quality assurance checks, health and safety information, risk assessments, meeting minutes and other records in relation to the management of the service.

Requires Improvement

Is the service safe?

Our findings

People told us they felt safe. Comments included; "Safe as houses"; "They [staff] are good lasses"; "It's a little worrying letting someone you don't know into your house, but touch wood, I have had no problems and feel safe with them [staff]".

Staff had been trained in safeguarding procedures and were aware of the whistleblowing policy.

When we asked staff, they knew how to recognise any issues relating to these topics and how to report any concerns, with no hesitation. One member of care staff said, "I really care about the people I support, I would hate to think of someone hurting them in any way." Where previous safeguarding concerns had been raised, these had been dealt with by the provider appropriately.

The service managed a small number of people's monies, which included getting items of shopping and holding money for safety. We checked the monies of four people which were held at the service. We looked at the process of receiving allowances into people's individual accounts and how the money was recorded when any transactions took place. We found that all money was present and correct and people had signed to confirm receipt.

We found some shortfalls in the recording of people's monies. One person had no running balance and no credit entries on the paper records, although money was noted as withdrawn by the person every day. This meant figures did not add up correctly and it was not until we went back through the electronic money management system that we were able to confirm their money was correct. Another person had money recorded coming in and going out with no balance. Another person had money coming in but no record of the money given out, although receipts were present and had not been recorded. We also noted that some people had cash held in the office as well as money held within an electronic 'client account', but no record of the total amount held by the service in individuals records. Any spend by staff was confirmed by two staff signatures and receipts were available.

We spoke with the registered manager and the staff member who completed finance monitoring and they both agreed that improved paper records were needed.

We saw that risk assessments were detailed and included the management of risks around malnutrition, diabetes, medication and social isolation. However, we noted that risk assessments were not always reviewed as regularly as they should be, particularly when people's needs changed. For example, one person had recently come out of hospital and their risk assessment had not been updated, although we found no impact had occurred with that person. We spoke with the registered manager about this and they told us they would look into this and make sure reviews were completed as they should be.

The service had an 'on call' system for out of hours so that people, relatives and staff could contact the service 24 hours a day. A handover was completed each time the 'on call' was passed to a different member of senior staff. This ensured they were aware of any issues that may have developed and also if any matters still needed to be resolved. For example, there was a record of one person being taken into hospital and a staff member phoning in sick. The provider's emergency contingency plan was available for staff. This would be activated in the case of a computer system failure or in bad weather conditions when staff travel arrangements may be affected. The plan was designed to ensure people would still receive the care provided by the service.

Accidents and incidents were recorded and monitored by the registered manager and the provider to help them identify any trends and to put in place any actions necessary to reduce the likelihood of the same accident or incident happening again. We saw that accidents had been recorded and dealt with appropriately.

People told us they were happy with the support they received with their medicines. One person told us, "The lasses help me take my medication. Without them I would be stuck." The medicines administration records (MARs) we checked had all been filled in correctly with peoples prescribed medicines with no missing gaps. However, we noted from reviewing daily records, that staff had applied prescribed topical creams to people and these had not always been entered on the MAR sheets. We spoke with the registered manager about this and they confirmed all medicines that were prescribed to people should have been entered on the MAR sheets, including topical creams. She said she would ensure that this was corrected immediately.

Requires Improvement

Is the service safe?

While visiting people in their homes we saw one person's daily notes indicated staff assisted them with medicines but there was no formal record of what this entailed. We also found a number of other people where staff supported them with their medicines but no detailed care plan or risk assessment was in place. The registered manager told us they were currently reviewing all records and she was aware that there were some gaps in recording. She also told us the provider was currently reviewing their medicines policy with the support of their regional clinical lead. We have made a recommendation regarding the management of medicines.

Staff ensured people's medicines were stored safely and told us they discarded them after the 'use by' dates had been reached. Staff said their medicines training was up to date and records confirmed this. Staff had undertaken competency assessments to show they had the skills and knowledge to administer medicines to people safely. We saw that staff were regularly observed giving out medicines to people by their line managers. All of the staff we spoke with were able to describe in detail what their role was in relation to medication with each of the people they provided care for, including what they would do in case of an incorrect dosage.

We found there were suitable numbers of staff to meet the needs of people using the service at the time of our inspection, although some people we spoke with complained about staff sometimes arriving later than planned. Comments included; "Carers are mostly on time, occasionally they are very late. They do sometimes call ahead if they're going to be more than 15 minutes late"; "They [staff] used to regularly be late. There has been some improvement in this recently but they seem really short-staffed. They don't give carers enough time between appointments" and "The girls are very friendly, lovely people. They did have some staffing problems last year but things seem to have stabilised now." Another person who had missed calls in previous years, told us, "Things have improved and the night staff are really good at making sure everything is within reach."

Two out of the 22 people that we spoke with over the telephone told us that they had occasionally experienced some problems with staff due to sickness or holiday. One relative said, "The consistency of staff is usually good, which is important because of my partner's condition. But even the new staff are well-briefed and I have no quibbles with them at all." Another person told us, "I have one main carer who is absolutely brilliant, so dependable."

During one of our inspection days a care worker called in sick. We saw that the provider was able to cover the care of each person at short notice but that they did not tell people that there would be a delay to their visit nor that they would be visited by an alternative member of staff. We saw that replacement staff were confident in their role and were well prepared to care for people they were not familiar with. For instance, a care worker who had not worked with one particular person before had remembered that he should be wearing hearing aids and was very good at identifying trip hazards around the person's home. While we were out visiting people in their own homes, the member of care staff received a call asking why she was running late. This showed that staff were monitored to ensure that calls were not missed and any delays were noted and checked on.

Overall, we found that although there were missed calls, these were kept to a minimum and were monitored by the provider to ensure that people were not left without a visit at all. Between April 2014 and April 2015 there had been 17 missed calls recorded. The registered manager and compliance and quality director explained they recognised missed calls would happen for unexpected reasons. They assured us they worked extremely hard to minimise the effect these missed calls had on people using the service by providing other staff to stand in where this had occurred. The compliance and quality director explained the provider was trialling a new rota system which they hoped would be implemented in this service in the near future. This would mean that any missed calls would be noticed quickly and actions taken sooner.

The human resource officer (HR) told us that she completed the interview and recruitment process for care staff with another HR colleague. She explained how they conducted interviews and the procedures they followed. The HR officer was very knowledgeable about the recruitment processes to ensure the best staff were chosen. Appropriate employment checks were carried out to ensure staff had been vetted before starting to work with people using the service. This included Disclosure and Barring Service Checks and ID confirmation. A new member

Requires Improvement

Is the service safe?

of care staff said, “The interview gave me a lot of confidence in the company. They gave me some difficult role play scenarios to deal with in order to prove that I could think on my feet and deal with the unpredictable.”

We noticed on the provider information return that a number of staff had left the organisation within the last 12 months. Staff records confirmed that the registered manager had dealt with a number of staff performance issues and had been involved with the provider’s disciplinary process on a number of occasions. Records confirmed she had dealt with these matters effectively and followed the correct procedures throughout.

We recommend that the service uses best practice in relation to the management of medicines, particularly around care planning and risk assessments.

Good

Is the service effective?

Our findings

Comments from people about staff training, skills and experiences were mixed and included; “They [provider] seem to have well trained staff”; “[staff name] knows what she is doing, she’s very good”; “I get good care from the experienced carers, they’ve had a lot of training. Some of the new carers haven’t got a clue what they’re doing”; “The more experienced staff are great, the younger ones are okay, they’ll get better with experience” and “When you get the consistent staff that you know, they’re excellent, they seem very well trained.”

Staff told us they completed an induction process. One member of care staff explained, “We get 15 hours of shadowing to start with but I had more because the people I am assigned to have complex needs. It was definitely enough, by then you’ve had all of your training and you’re ready to start working with people properly.”

One member of care staff commented, “The training is fantastic, we’re very well supported by management with anything like that.” Records showed that 85% of care staff had achieved a level two qualification in health and social care, and 40% were working towards the level three qualification. We looked at the training spreadsheet completed by the provider to monitor all staff training and saw that staff training was up to date.

One person told us, “I now need a hoist to move from my chair to the bed at night, that was something new for the staff. The occupational therapist worked with them [staff] and they have it down quite slickly now.” We saw that two staff were always present to support people who needed a hoist and that in all cases we observed staff talked people through how they would be supporting them with the hoist before they started moving people. One relative told us, “You couldn’t ask for a better group of staff, I’ve got the highest praise for them. [Person’s name] can sometimes be aggressive because of her condition but the staff are great with her, very well trained.” Evidence was available to show that healthcare professionals had supported the service with individual training or advice, specific to people’s particular needs. For example, the registered manager told us that the ventilation team based at the local hospital had provided a good source of support to the team. We confirmed this during a conversation with a member of the hospital team.

All staff training needs were reviewed on a regular basis through supervision and end of year appraisals. The registered manager had organised for ‘dementia friends’ training to be provided and one of the senior staff was going to take the lead on ensuring this was rolled out to all staff to become a dementia friend. Dementia friends training is completed by ‘champions’ in the local area. Champions are trained volunteers who encourage others to learn a little bit about dementia. Champions run Information Sessions in their community and inspire others to help those living with dementia live well.

Staff gave us inconsistent messages when we asked them if they had regular supervisions from a manager. None of the staff we spoke with were able to tell us how the supervision system worked or how often they had a supervision. They told us they felt supported but said the support they had received from managers was informal and could not tell us about any formal arrangements in place. The registered manager had introduced a checking process to ensure that staff received regular supervision and we saw evidence of this. Records showed that staff had previously received supervision individually and as a group, although these had been sporadic. One staff member told us, “I’ve been here three years and I’ve only just been asked to have an annual appraisal. Another staff member told us they had their appraisal booked in the diary for the following week.

The registered manager told us (and we confirmed via the records) that she was conducting everyone’s appraisal this year and monitoring to ensure that supervision had taken place. She explained this was her first year in the service and that she wanted to use this opportunity to get to know staff better and ensure everyone had performance needs supported and clear objectives set via their appraisals. She assured us that staff meetings had an element of group supervision and that she was striving to ensure that staff attended these.

One member of staff told us that care workers did not routinely check the communication log before providing care to a person. However, when we asked other staff about this, they contradicted what we had been originally told. One member of care staff told us, “The first thing I do when I arrive is log in and then I check any notes from other staff.” They continued, “There is a lot to do in a short space of time, but it’s so important that we don’t miss anything.” We passed this information on to the registered manager who said they would address this immediately.

Good

Is the service effective?

People had consented to receive care and support and we heard staff asking people before they began with a particular task, for example providing personal care. Staff had an awareness of procedures involving people who may lack capacity and had received suitable training. The registered manager was able to explain what involvement the court of protection may have with people. The Court of Protection in English law is a superior court of record created under the Mental Capacity Act 2005. It has jurisdiction over the property, financial affairs and personal welfare of people who it claims lack mental capacity to make decisions for themselves.

Records confirmed that staff had supported people with appointments or referrals to other health care professionals as the need arose. For example, one person had required additional support from the speech and language team (SALT), due to their risks around food and choking and we saw the SALT team had been contacted and involved.

Staff supported people in their own homes with the preparation of meals and people that we spoke with were happy how this was conducted and satisfied with what was prepared. One person told us, “They [staff] leave something for me because I usually like it later.” Staff had received food hygiene training, which meant they were able to prepare food safely.

Good

Is the service caring?

Our findings

People and relatives were complimentary about staff, and a number of staff were singled out as going the extra mile. We passed their names on to the registered manager. Comments from people included; “I’m happy with the care, it is a really good service”; “The main carer who comes here is absolutely fantastic”; “The carers who come out are friendly and understanding and they have enough time to spend with us. You couldn’t ask for a better group of staff, I’ve got the highest praise for them” and “The staff do a lot for me as I can’t do much and really need their help. I can’t even move around much in my own home so I am lucky they are so good. They are really patient and caring with me”. A healthcare professional said, “Staff are caring and have the clients best interests at heart.”

Staff were very good at talking to people and reassuring them whilst providing personal care. Staff said to one person, “Just relax, we’re just giving you a wash so you can have a lovely breakfast with your wife, you’ll feel much better after this.” During a hoisting procedure, staff said to a person, “You’re all strapped in, your hands might slide down a little bit while we move you but you’re not going to fall so don’t worry.” We noticed that reassurance like this appeared to come naturally to staff, regardless of how long they had worked for the provider.

One member of care staff complemented a person on how smart they looked by saying, “They’re a lovely pair of trousers – what a great colour!” We saw that this had an immediate and very positive impact on the person.

Staff encouraged wellbeing and promoted independence. For example, in one record we saw that staff were told that the person would initially refuse to go outside for a walk but that they should persevere because the person always enjoyed it once out. We asked the person about this. They said, “The carers try to get me out and about and to be more mobile.

In all cases we were told that the care plan had been a collaborative exercise, and that people were involved in planning their care. In many cases district nurses and other health or social care professionals had also been involved. Care plans enabled staff to respond to the diverse cultural needs of individuals. We saw that one person’s care and support package was tailored around their ‘pray’ time. Care plans were in place to describe how staff should support the person with daily cleansing in connection with this. The care plan also described other actions care workers had to follow to respect the religious beliefs of the person.

One person we visited was not able to receive support with a bath or shower that particular day because they preferred a male care worker and the provider was not able to supply one at short notice because of sickness. They said, “My usual carer is fantastic, he’s like a brother, everything he does for me is great. I know today’s carer too, she covers sometimes, she’s the only female I will let look after me but it’s a shame I won’t get a shower today.” We spoke with staff about this and they explained that male staff were difficult to recruit to this line of work, but they continually strived to employ more males and other people to make the team more diverse.

We saw that staff had well-developed communication skills and were able to interpret and respond to people who could not communicate verbally. For example, one person who had suffered from a stroke used gestures or pointed and staff were able to understand what that meant.

Two dignity champions had been appointed. Dignity champions are staff members who are appointed to gather good practice in this area and ensure that all staff were made aware. In all cases staff were respectful to people and showed awareness of their privacy and dignity. For example, during one visit a care worker asked us to move into another room whilst a person had their lunch because they did not like to eat around other people but would be too embarrassed to ask us to leave. Staff were observed shouting through to people to alert them to the fact they had arrived after they had let themselves in. Staff were able to let themselves in via a secure key box at the property where people had given their permission to do so.

Requires Improvement

Is the service responsive?

Our findings

Although we found some care plans were detailed, this was inconsistent. For example, one person's care plan had not been updated since March 2014, despite the person's care needs changing considerably after a period spent in hospital. We asked staff how they knew what to do if care plans had not been updated. One member of staff said, "The manager just calls up and lets us know."

We found that one person who had recently started to use the service had no risk assessments in place and their care plan simply instructed staff to do what they were told by the person's relative. We found that many care plans that we looked at were task orientated rather than being person centred. One person told us [talking about their care plan], "[Staff name] did everything in his task sheet."

We found that people's identified needs were not always care planned, for example, those with communication needs or those that needed support with medicines management. We spoke with the registered manager about this and they told us that documentation was in the process of being reviewed and she was aware that some paperwork lacked information. She showed us a number of detailed care plan's which the regional clinical lead and herself had been involved with and explained that was the level of detail she expected to see in all documentation. People told us that they received a good service from caring staff. However, we found that although documentation was being reviewed, new people to the service had poor documentation in place and there was still a significant number of care records that had not yet been reviewed.

This was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Comments from people included; "One of them [staff] suggested I might like a slide transfer instead of a hoist. This was great, I much preferred it" and "Due to a broken leg I needed proper care for about five weeks and they were excellent."

People starting to use the service for the first time had their needs assessed by one of the senior team. This included the type of support they required, what the person's needs were, and any other information that would support the staff team to provide individual care to the person. Staff told us that they were usually scheduled to visit the same people on a regular basis so that they got to know them and understand their needs. We saw from observing people and staff and from talking to people that when staffing was consistent, they felt that they received the best care.

Most people did not have recreation as part of the support provided by care staff. However, one person told us that staff supported them to get out for walks from time to time. Another person told us that if they wanted to do things in a different way, the staff would help them. They said, "I normally get up, have my medicine and something to eat and then listen to music. If I wanted to stay in bed, [staff name] would just leave me and make sure I had taken my medicine and had something to eat. She's very good if I change my mind."

A number of people we spoke with said there seemed to be issues with communication. One person told us, "Staff tell me they ring the office when they are running late, but that does not get passed on to me, which is frustrating as I get anxious when the lasses are ever late – although I have to say, that is not often." One relative told us "I asked [provider] for a later evening call three and a half weeks ago but they haven't got back to me about that yet." A further three people told us that if staff were running late, they were never told and a number of other people told us they had problems getting through to the office when they called. We sat in the office where calls come through during part of the inspection and found that staff answered calls as they came in. We noticed that there was an answer phone and this would cut in if the call remained unanswered. Where this did happen on three occasions, staff rung the caller straight back. From conversations with the registered manager, calls from people or relatives were important and this would be reviewed.

Compliments had been received at the provider's office, including cards expressing thanks from people and their relatives after they had received good quality care and support.

The provider had complaints procedures in place and people were provided with information to explain what they should do if they needed to make a complaint. We noticed that the number of complaints had reduced since the current registered manager had come into post. One person told us, "I did have to make a complaint once but it was sorted out very quickly. I am definitely happy with the

Requires Improvement

Is the service responsive?

service I get." Another person said, "I've very little to complain about as they are very good." One person told us that since they had complained, everything had improved and they were happy that a manager had taken them seriously.

Requires Improvement

Is the service well-led?

Our findings

At the time of our inspection there was a registered manager in place. Our records showed she had been formally registered with the Care Quality Commission since November 2014. She was present at the service and assisted with the inspection. The registered manager had worked in social care for many years and was committed to providing a good quality services to the people she worked for.

The provider had a management team in place to oversee the operation of the service. This included a managing director, regional manager, compliance and quality director, operations manager, registered manager, regional clinical lead, team manager, coordinators and supervisors as well as recruitment and training personnel. Staff knew what their responsibilities were. We had an open conversation with the management team and they explained they were continually striving for ways to improve. We spoke at length to the regional clinical lead who explained her role in promoting good nursing practice across the service and how they were supporting staff to implement this in the work they did.

The provider was an employee owned organisation and offered staff an employee rewards programme. This included a share incentive scheme and a staff discount programme. We asked staff about the share incentive scheme but some staff were not aware of what that was and one staff member thought it did not exist any longer. The registered manager told us she could not understand why staff thought that, because it was discussed in meetings and information sent out to staff which she was able to show us.

We found that yearly surveys were sent out to people and their families to complete. These were analysed by the registered manager to look for trends or ways to improve the service. We noted that there was no space on the survey forms for people to put their names if they wanted to and no date, which meant that where people had made comments requiring a follow up this was not always possible unless a name was given. The registered manager explained that the forms were anonymous but she had already recognised that there should be a space for people to put their name if they wanted their comments to be followed up and also a date. Out of the 64 survey forms received back, we saw that the majority of people had scored the service between excellent and very good. One person wrote, “Dad looks forward to [staff name] visits to whom nothing is too much bother.” Another person had commented on how happy they were with the service, “Very happy.”

Organisational meetings were planned to take place with staff representatives from each areas, including a representative from people using the services. The representatives from this service included the registered manager and one of the coordinators. The meeting had been set up to hear the views of staff and people using the services and look at ways to improve quality. We saw minutes and agenda items included, staff turnover, new care certificate, policy launches and audits.

Team meetings were held at various times to accommodate all staff, and topics covered on the agenda were; compliments, complaints, continuity, actions from handover, safeguarding concerns, and missed calls. Staff told us the meetings were a good way of gaining updates.

The senior staff completed regular observations and spot checks of staff to monitor performance and the service people received. This included length of stay with the ‘client’, was the correct level of care delivered, was the person addressed by the name they preferred, were people treated with respect, observations of personal care and had procedures been followed. Where issues had been identified this had been discussed with staff and addressed accordingly.

Log book audits were carried out by senior staff by checking daily entries, including dates, times and assurance that all visits commissioned were made and recorded. Client file audits were undertaken by senior staff and this included a check to ensure that all relevant paperwork was in place. We saw from these audits that the issues we found with care records had been noted and responses made although further work needed to be undertaken.

The provider completed regular audits which covered a range of areas, including; recruitment, complaints, care records and quality of the service provided to people. We saw that where issues had been identified, these had been given a date for completion and followed up at the next

Requires Improvement

Is the service well-led?

audit undertaken. For example, there was an action to enter the outcome of any complaints in the electronic system used called 'carefree'. We saw that this had taken place.

All of the staff we spoke with said they liked working at the service. One said, "Some staff always think the grass is greener elsewhere, but we are better than some." Another staff member said, "They treat you well if you work well, which is fair enough." All of the staff that we spoke with said that they felt supported by their manager and by the provider. When we asked if there was anything they would change about the service or the way it was managed, most staff said they wished mileage payments could be changed as that had an impact on their work and finances. The compliance and quality director told us that the issue about mileage payments had been taken to the 'board' and an outcome was awaited.

The registered manager had not sent us recent notifications about two deaths that had occurred while staff provided care to people in their homes. Notifications are changes, events or incidents that the provider is legally obliged to send us without delay. The registered manager sent us the notification in retrospectively and apologised for the delay.

This section is primarily information for the provider

Action we have told the provider to take

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

Regulated activity	Regulation
Personal care	Regulation 17 HSCA (RA) Regulations 2014 Good governance **Regulation 17(2) (c)** **The provider had not maintained accurate and complete records in respect of all service users, including a record of care provided.**