G.R Response Healthcare Ltd

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

What life was like for people using this service:
• The service made numerous improvements since our last inspection.
• The safety of people's support and the quality monitoring of care processes were improved.
• People and relatives told us staff were kind and caring. They could express their views about the service and provide feedback.
• Staff received appropriate training and support to enable them to perform their roles effectively.
• People's care was personalised to their individual needs. There was sufficient detail in people's care documentation that enabled staff to provide responsive care.
• There was a complaints system in place, however further improvements are needed to ensure it is always robust.
• The service had processes in place to measure, document, improve and evaluate the quality of care. More time is required to ensure that the processes are effective and sustainable.
• Changes were implemented to the management team to encourage a continuous improvement process at the service.
• The service met the characteristics for a rating of "good" in all key questions.
• More information about our inspection findings is in the full report.

Rating at last inspection:
• The rating of this service at our last inspection was "requires improvement".
• At our last inspection, there were four breaches of the regulations.

About the service:
• G.R Response Healthcare is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to younger and older adults, people with physical disabilities, sensory impairments, learning disabilities or dementia.
• The service's office is based in Langley, and personal care is provided to people in surrounding areas.
• At the time of our inspection, 30 people used the service and there were 30 staff.

Why we inspected:
• All services rated "requires improvement" are re-inspected within one year of our prior inspection.
• This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
• We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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.

Details are in our findings below.

Is the service effective?

Good

The service was effective.

Details are in our findings below.

Is the service caring?

Good

The service was caring.

Details are in our findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our findings below.

G.R Response Healthcare

Detailed findings

Background to this inspection

The inspection:
• We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was 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.

Inspection team:
• Our inspection was completed by two adult social care 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. Our expert-by-experience had knowledge about personal care of adults within the community.

Service and service type:
• The service is required to have a registered manager. 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 inspection, a manager was registered with us.
• Our inspection process commenced on 26 September 2018 and concluded on 24 November 2018. It included visiting the service's office and telephoning people who used the service and their relatives. We visited the office location on 24 November 2018 to see the registered manager and office staff, and to review care records and policies and procedures. We telephoned people and relatives on 26 September 2018.

Notice of inspection:
• Our inspection was announced.
• We gave the service 48 hours' notice of the inspection visit because the registered manager was often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We

checked records held by Companies House and the Information Commissioner's Office (ICO).
• We did not ask the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
• We telephoned and spoke with one person and six relatives to gather their feedback.
• We spoke with the registered manager, the quality and assurance manager, recruitment and training manager, a care manager and a care worker.
• We reviewed five people's care records, two personnel files, two medicines administration records and other records about the management of the service.
• After our inspection, we asked the registered manager to send us further documents to our national customer service centre, so that alterations to the registration records could be made.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm.

At our last inspection on 16, 17 and 18 October 2017, this key question was rated "requires improvement". This was because we found evidence that people were concerned about the timeliness of their calls, people were not always protected from avoidable harm and medicines management was not always safe. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken steps to improve the safety of people's care. Therefore, the rating for this key question has increased to "good". Further improvements to ensure people's safety are ongoing.

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes:
• The service made improvements to ensure the documentation of all alleged abuse or neglect were robust. This included keeping a full set of documents related to any case raised. A log of events was also maintained by the service.
• There was evidence of the service working with the local authority and police (where necessary) when investigations took place.
• The provider sent relevant referrals to the local authority when there were concerns about people's welfare.
• The service had records to show they followed up on the outcomes of cases. There was one ongoing investigation where a conclusion was not reached at the time of our inspection.
• One allegation of abuse against a person could have been better managed by the service. We provided advice to the registered manager about this.
• Staff continued to receive training in safeguarding and whistleblowing. They knew how to report matters to the management team and other agencies.
• People and relatives told us they felt the service was safe. Comments included, "Well I do feel safe. I don't really think about it. I've never felt unsafe even if [care workers of a different gender] come" and "I would say yes. Not only am I at home with [the person] but the carers are very good. We tend to get the same staff most of the time…"

Recruitment and staffing levels:
• The service operated an 'always on' recruitment campaign. This was a proactive drive to ensure there were always enough competent care workers employed.
• We received information leading up to our inspection which alleged staff were not properly vetted before commencing in their roles. Our inspection found that this was unsubstantiated. The service had completed all the checks needed to ensure fit and proper staff were employed.
• We examined two personnel files which contained all the necessary documentation required by the relevant regulation and schedule. This included proof of identity, criminal history checks from the Disclosure and Barring Service, checks of conduct in prior roles, full employment histories and relevant qualifications.

• Applicants for roles were required to complete a pre-employment questionnaire to check their knowledge and opinions about safe and compassionate care. This was followed by a face-to-face interview with one of the managers.
• All people who received care from the service had complex needs. This meant each call was completed by two care workers.
• We checked computer systems which showed how staff were deployed in geographical area, the times of the calls, and the start and end times for calls.
• Live monitoring, even outside standard business hours, enabled the management team to be aware of late or potentially missed calls. The managers could then call care workers to check for any issues and rearrange care calls if needed. People and their relatives were also advised of any late calls or schedule changes.
• The office hours were changed to open one hour earlier at breakfast. This allowed the care manager to be aware of any issues with staffing or calls during the busiest time of the day.
• We received feedback that calls were generally on time. Comments included, "They [are on time] if they don't have an emergency", "Mainly [on time] or within 10 minutes. They always tell me if they are going to be late especially if there is an emergency", "Sometimes they might have a person before me that might be a bit troubled, but generally they are good" and "More or less. Occasionally they arrive late but that is expected. I don't worry about it because I know they'll come."
• The managers showed us how they worked with the commissioners if a person required additional time for their personal care. This ensured sufficient funding to increase the amount of time or frequency of calls to people who experienced deterioration in health.
• The service had acted on the recommendation from our prior inspection report by reviewing the allocation of staff to care calls.

Learning lessons when things go wrong:
• The service made improvements to the recording and management of incidents and accidents.
• Care workers reported any harm to people via calling the office. They also logged incidents in the care management system.
• The care manager made notes on an accident form. This was then reviewed by one of the management team.
• We reviewed a variety of the accident forms. We found adequate details were recorded, and that the managers had reviewed the information and made further notes or started investigations. For example, one person sustained frequent falls. The service organised for a home assessment to occur so that appropriate equipment could be provided.
• Incidents and accidents were analysed at the end of each month. There were no identified trends or themes.
• 'Learning points' from safeguarding cases were created by the management team. These were distributed to the staff so that they could ensure the safety of people. An example was how to ensure the safe management of people's money to protect them from financial abuse.
• Appropriate action was taken by the service when needed. One person told us, "I had to call about the key safe as they [staff] left the key in the front door a few times. They were very apologetic, they disciplined the staff and they wrote a letter to apologise."

Using medicines safely:
• The management of medicines had improved. The service had reviewed how the administration of medicines were recorded.
• Staff were required to complete training and a competency assessment prior to administering medicines on their own. Training consisted of an online course, a practical demonstration of 'blister' packs and medicines administration records (MARs) and shadowing an experienced care worker.
• The administration of medicines was recorded in the electronic care documentation system, but

additionally on paper MARs from September 2018.
• The paper records were scanned and attached to people's electronic care records. Both sets of MARs were audited for missed signatures.
• Most people and relatives we spoke with managed their own medicines. One family member told us they had "no issues" with the service's management of the medicines.
• We suggested that the service documents the times for administration of medicines, rather than using "morning" or "evening". The managers agreed and told us they would implement this during the next month.

Assessing risk, safety monitoring and management:
• The service aimed to obtain as much information about a person before a new care package commenced. This included assessments from the commissioner, timings of planned calls and care needs. The information was mostly received by e-mail and promptly assessed.
• If the person was in hospital, they were visited and assessed by the managers. The service also spoke with the hospital staff and the family members to gather relevant information about risks.
• The staff asked about any pre-existing referrals of the person to other agencies. The registered manager explained that they had previously received "sketchy" information from stakeholders. They routinely asked at the assessment stage so that all relevant factors were taken into consideration before a care package commenced
• The staff considered any reasonable adjustments for people with identified disabilities. For example, relevant moving and handling equipment was arranged for people who required hoisting.
• Risk assessments contained satisfactory information. These covered activities of daily living such as skin integrity, nutrition, moving and handling, catheter care and multidisciplinary healthcare.
• Appropriate risk assessments of people's homes were carried out. Staff told us changes were made because of discussions with people, relatives, care staff and managers that made the environment safer for all.
• One person's bedroom was located from a first floor to the ground floor, as they had trouble mobilising to the upper floor. On another occasion, the fire brigade was called to help move a person because their mobility lift had malfunctioned.
• A family member commented, "The [person's] hoist is maintained and the area around him is safe and they [staff] do checks on his hoist, bed and slings.
• Where the service could no longer safely support a person, they contacted the commissioner to organise transfer to another care provider.

Preventing and controlling infection:
• People were protected against infections.
• Staff were trained in infection prevention and control and had access to personal protective equipment like disposable gloves and aprons.
• Staff received information and competency checks for effective hand hygiene.
• The service did not have a designated member of staff responsible to act as a 'champion' or 'lead' for infection control. We spoke to the registered manager about this. They were receptive of our feedback and provided reassurance they would plan to ensure this happened.
• The provider had installed a shower at the service's office address. This was so that any staff who had experienced exposure to body fluids could access appropriate facilities to prevent cross-contamination during their calls.

Good

Is the service effective?

Our findings

Effective – this means that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence.

At our last inspection on 16, 17 and 18 October 2017, this key question was rated "requires improvement". This was because we found evidence that the service was not compliant with the provisions of the Mental Capacity Act 2005 (MCA). Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken steps to improve their compliance with the requirements set out in the MCA. Therefore, the rating for this key question has increased to "good".

People's outcomes were consistently good, and people's feedback confirmed this.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

• Staff ensured that people were involved in decisions about their care, and understood the procedures to make sure decisions were taken in people's best interests.
• Staff received further training to ensure their knowledge and practice reflected the requirements set out in the MCA.
• The management team had also increased their knowledge of the provisions set out in the legislation.
• More detailed information about people's capacity was recorded within the care documentation.
• Staff understood the concept of capacity, fluctuating capacity and understood the relevance of that impacting on personal care decisions.
• People we spoke with told us they were always asked for their consent prior to any personal care being undertaken. This was confirmed by staff we spoke with and by reading care documentation.
• Where possible, people, or their next of kin, had signed the care records to show that they had consented to their planned care, and terms and conditions of using the service.
• People were asked for their consent before support workers delivered care to them, for example, with personal care or assisting them with their medicines. This was always gained prior to any procedure daily, and was documented.
• Initial capacity assessments were undertaken by senior managers.
• Documents clearly indicated exactly what people consented with, and where particular requests had been made.
• Where English was not a person's first language, the record system used could auto-translate forms for this, when needed.

• Relatives confirmed consent was obtained from people. Comments included, "My dad knows what they are going to do; they [staff] have their own routine", "Yes, they do [seek consent]" and "Yes, they [staff] do tell him…we're going to roll you over now…"

Assessing people's needs and choices, delivering care in line with standards, guidance and the law:
• Assessments of people's needs we saw were comprehensive, expected outcomes were identified, and care and support regularly reviewed.
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.

Staff skills, knowledge and experience:
• Staff training, supervision and support was in place. The induction process could be further enhanced with the new training manager in place. Shadow spot checks of competence and practice were undertaken.
• A brief Induction took place in the provider site office. This was basic, with a focus on systems and processes for the running of the business. We provided feedback to the registered manager regarding the induction effectiveness, and they were receptive of our findings.
• After induction, new staff undertook four shadow shifts with two other care workers, then as the second staff member on a two-person call.
• Senior care workers taught new care workers in people's homes, training them with the appropriate and safe use of hoists and slings.
• E-learning via an accredited company was undertaken by all care workers. This was done either in the office or remotely from employee's homes. This comprised of three modules of person-centred care, safeguarding, moving and handling, and safe medications management.
• The training manager undertook the care worker's supervision sessions, to review practice and to sign them off for medicines administration competence.
• All new staff had a six-week supervision interview.
• Staff were competent, and skilled at practical tasks.
• Staff had adequate training, supervision and appraisal opportunities. One-to-one meetings were held regularly, and appraisals took place annually.
• People and relatives felt staff were skilled. They said, "Oh yes definitely. They always have a laugh and a joke with him [the person], "Yes, they [staff] are skilled and they always have her [the person] laughing", "Yes, the ones I have seem to be quite good. I have no complaints about them. Yes, I do get on with them" and "Yes, I do, the ones that come here are good. They have been coming here for a long time."

Supporting people to eat and drink enough with choice in a balanced diet:
• People were protected from malnutrition and dehydration.
• Where people required assistance, they were supported to eat and drink enough and maintain a balanced diet. Some people were supported by the delivery of a contracted food delivery company.
• Where care workers identified concerns, for example, with people maintaining a safe and healthy weight or if people were at risk of choking, they contacted relevant health professionals for treatment and guidance.
• Where guidance had been provided relating to people's dietary needs, care workers recorded this in people's care records to guide colleagues in how risks were reduced. One recent episode had occurred where a person started to choke on food. This person was looked after safely, with a good outcome.
• Where people required their food to be prepared differently because of medical need or problems with swallowing this was catered for. Where required, care workers used fluid thickeners to enable fluids to be safely administered in a consistent manner. This practice was guided by district nurses.

Staff providing consistent, effective, timely care within and across organisations:
• The service and staff continued to work with other community stakeholders to ensure effective care for

people.
• The registered manager stated that the changes made in staffing structure since our last inspection would help further improve the service.
• The service evaluated their interactions with people, relatives, staff and other professionals. Where necessary, changes were made to practice and operations.

Supporting people to live healthier lives, access healthcare services and support:
• There was access to healthcare professionals such as GPs, community nurses and dietitians, to ensure that people led safe and healthy lifestyles.
• Care workers contacted these for professional and specialist healthcare referrals. For example, the service ensured people at risk had swallowing referrals, continence assessments, and palliative care specialist input.
• Where people required this specialist support from healthcare professionals, this was arranged and staff followed guidance provided by such professionals.
• Information was shared with other agencies if people needed to access other services, such as hospitals.
• A relative told us, "They [staff] gave her [the person] a stress ball for her hands. They check her for bed sores. They often tell me that her pad isn't very wet, which means she's not drinking enough, so yes I get feedback which helps me with her food and fluid intake."

Good

Is the service caring?

Our findings

Caring – this means that the service involved people and treated them with compassion, kindness, dignity and respect.

At our last inspection on 16, 17 and 18 October 2017, this key question was rated "requires improvement". This was because we found evidence that people were not encouraged to express their views or involved in decision-making. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken steps to improve the people's and relatives' involvement in the care and support received. Therefore, the rating for this key question has increased to "good".

People were supported and treated with dignity and respect and involved as partners in their care.

Ensuring people are well treated and supported:
• People and relatives were more involved in care decisions and expressing their views.
• The service took steps to ensure people had choices in their care and could provide feedback more often.
• The management team visiting people more often. This was to ensure that care plans were updated with people, relatives and when necessary their advocates. There was evidence that the office staff were more involved with supporting people with their choices.
• Documentation indicated that more people and relatives agreed to the planned or reviewed care. Signatures of all involved were evidence in the care records.
• Telephone calls were made to people to gather their feedback on a regular basis. Office staff contacted people to check the status of their care package and gather informal feedback. The staff also checked whether any changes were requested or needed.
• We observed the care manager deal with a difficult telephone call with a person. They were calm and polite, and tried to explain things in a sensible manner. At the end of the telephone call, the care manager explained the person called frequently and that they knew how to manage any feedback. There was consistency to how the care manager dealt with the person's feelings.

Supporting people to express their views and be involved in making decisions about their care:
• All the people and relatives we telephoned told us that staff were kind and caring.
• Comments included, "Oh yes, they [staff] are caring. They are always asking him [the person] if he's comfortable like do you need a pillow, do you want your glasses, do you want to wear your socks, are you cold…", "They [staff] notice things like her hands and they will check she doesn't have boils. I think that's the main thing that they are looking out for her", "Yes, they [staff] are very kind. There's one that you probably like more than others but that's how it goes. I have a carer called [staff member's name] and we get on very well. ", "Yes, very, I do find them very caring. Yes, they know how he is…they understand him [the person]" and "They [staff] are caring and they look after him, ask him if he's comfortable, does he want to change positions. They do ask him."

Respecting and promoting people's privacy, dignity and independence:

• Staff we spoke with expressed their responsibility to ensure people's rights were upheld and that they were not discriminated against in any way.
• Staff gave us examples of working well with relatives to provide care in an integrated way. For example, relatives often assisted interpret information for people from English into other languages.
• People and relatives provided feedback about how the service promoted independence. Feedback included, "They [the service] have some information in her [the person's] 'red book' about advocacy. I will ask the carers anything I need to know, as I have a good relationship with them", "At the moment there isn't anything else I need, but I suppose if I asked they [the staff] would help" and "They [staff] would if there was something, but there isn't."
• People and relatives explained that staff respected their privacy and provided dignified care. Comments included, "Yes, they [staff] will cover him up when he's on the commode and really do respect him", "When they [staff] come in and my husband is here they are very respectful. They cover me when I'm being dressed", "If they [staff] are going to wash him [the person] they will ask us to leave the room" and "They [staff] make sure the curtains are closed in the bedroom and they don't allow anyone else in the room when he's [the person's] being washed."

Good

Is the service responsive?

Our findings

Responsive – this means that services met people's needs.

At our last inspection on 16, 17 and 18 October 2017, this key question was rated "requires improvement". This was because we found evidence that people were not involved in care planning and reviews. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken steps to improve the people's and relatives' involvement in the care and support received. Therefore, the rating for this key question has increased to "good".

People's needs were met through good organisation and delivery of care.

The provision of accessible information:
All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.

• The care notes documented that the service identified and recorded communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it.
• Care documentation explained what communication aids such as glasses and hearing aids, people required as part of their daily lives.
• A staff member employed was proficient in British Sign Language, and therefore could communicate with people with hearing impairments who used signing.
• The service had an arrangement in place for the prompt processing of documents into Braille. This would ensure that people who could understand Braille would have accessible information provided to them.
• The service could further develop accessible information by considering the use of large fonts, easy-read words and incorporation of pictures or symbols into documentation.

Personalised care:
• People had a care planning folder kept in their own home, accessible to all healthcare professionals. Care plans included physical, mental and social needs, and any tasks which needed to be completed on visits.
• Staff knew and understood people's likes, dislikes and preferences, and used this knowledge to care for people in the way they wanted.
• People were enabled to make choices in their care plan provision, and had control and independence as they requested or were able, including in the ongoing reviews of care, support and treatment plans.
• Relatives were involved where or when service people requested and consented to that.
• People's needs were identified, including those related to protected equality characteristics, and their choices and preferences were regularly met and reviewed.
• People and relatives told us their needs were properly assessed and reviewed. Comments included, "It was all arranged and the carers were here when he [the person] got home. Then [the registered manager] came

over and spent two hours with us. We have a folder that outlines his care and phone numbers etc. She went through everything with me", "Yes, they did an assessment and went through all sorts of things like what she needed, what I needed, food, what her routine is. I think this has been done a couple of times since", "Yes, they were very good…they listened" and "Yes, they did come around; in fact, various people did including the council."

Improving care quality in response to complaints or concerns:
• The management of complaints by the service requires further improvement. The systems are not fully robust, although there were changes since our last inspection.
• People who used the service, and their families, knew how to provide feedback about their experiences of care, and the service provided a range of accessible ways for this to be done.
• People and relatives knew how to raise concerns or make more formal complaints should they need to.
• We reviewed a few complaints, and noted that there was some inconsistency in the timeliness and methods of response. For example, sometimes full written responses had been made, outlining the actions taken, on what date and involving specific named individuals.
• However, not all responses had the same degree of either timeliness or rigour, and this would benefit from a more consistent and regularly reviewed approach.
• All the people and relatives we spoke with said they knew how to make a complaint if needed. One said they had raised a complaint and this was resolved to their satisfaction. One family member stated, "Yes of course I would raise a complaint. I would speak to the owner or the manager."

End of life care and support:
• Staff understood people's needs, were aware of good practice and guidance in end of life care, and respected people's personal, cultural and religious beliefs and preferences.
• People were supported to make decisions about their preferences and staff empowered people and relatives in developing care and treatment plans. Other healthcare professionals such as GPs, community and palliative care nurses were involved as appropriate.
• The service provided medicines at short notice to ensure people were comfortable and pain free.
• The service continued to support families and friends before and after a person died.

Good

Is the service well-led?

Our findings

Well-led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

At our last inspection on 16, 17 and 18 October 2017, this key question was rated "requires improvement". This was because we found evidence that quality assurance processes were not effective at driving improvement. Following our last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key question safe to at least "good". At this inspection, we found the service had taken some steps to improve the governance of the service and quality of care people received. Therefore, the rating for this key question has increased to "good". Further work is required by the provider and the management team to continue improvement of the governance processes.

The service was consistently managed and well-led. Leaders and the culture they created promoted good quality, person-centred care.

Engaging and involving people using the service, the public and staff:
• The service increased the use of surveys to gauge feedback. They analysed the findings and developed an action plan to highlight areas for improvement.
• People and relatives told us they received and returned surveys. Some expressed that there was a large volume of questions.
• In September 2018, 30 surveys were sent out and 14 people (or relatives) responded. More than 80% of the respondents expressed they agreed or strongly agreed that the service was caring.
• Actions taken to address identified improvements included creation of a reminder card for people with emergency services' telephone numbers and the service's out of hours number. Another example was managers spoke with staff to remind them about the safeguarding policy, record keeping and complaints management. The quality and assurance manager then telephoned or spoke face-to-face with three care workers to check whether the information provided was used by the staff. The staff he spoke with retained the knowledge of what the management team had asked them to do better. This programme was in place on a rolling basis, with different topics and different staff.
• The provider could further explore the use of popular service review websites to encourage more people and others, to provide feedback on an ongoing basis.

Provider plans and promotes person-centred, high-quality care and support, and understands and acts on duty of candour responsibility when things go wrong:
• All adult social care providers are required to have a statement of purpose (SoP). The service had a satisfactory SoP which set out the aims, objectives and ethos for care. Objectives in the SoP included, "Offer skilled care to enable people supported by us to achieve their optimum state of health and well-being" and "Treat all people supported by us and all people who work here with respect at all times."
• When we asked the management team, they could clearly explain the ethos of the service and how this applied in the provision of care and support to people.
• A satisfactory business continuity plan was in place. This would ensure that people's care could continue,

where possible, if unforeseeable events occurred. This included shortages of staff, extreme weather or traffic congestion. When needed, the management team assisted care workers in the provision of care to people to prevent disruption to the scheduled calls.
• Unannounced 'spot checks' involved managers checking staff practice. Managers checked staff were punctual, dressed in their correct uniform, had identification, carried out care according to people's plans, were vigilant for hazards, ensured safe hygiene, were suited to the person, completed progress notes, and asked people about their experiences of care.
• We viewed evidence of staff spot checks and the outcomes. We saw remedial actions were taken with staff when necessary, to ensure that care was provided in the right way.
• People and relatives confirmed they had contact with the management team of the service. One relative said, "Yes, I don't have to do much, because the carers are so good." Another relative said, "They [managers] have always been good to me. A further relative stated, "I have had dealings with them [managers] before, with no problems."
• There was a daily task schedule which set out responsibilities for the service's office-based staff.
• People were protected against discrimination. There was a policy which covered the Equality Act 2010 and protected characteristics.
• We recommend that the service explores further avenues that enable the protection and promoting people's equality, diversity and human rights.

Managers and staff are clear about their roles, and understand quality performance, risks and regulatory requirements:
• The registered manager was clear about their role and the expectations of them as the legally accountable person for the safety and quality of all people's care.
• Additional managerial staff were appointed since our last inspection. The registered manager explained this was to ensure improvements to the quality of care were made and sustained.
• New roles included the quality and assurance manager as well as the recruitment and training manager. The managers had commenced in the months leading up to our inspection. There was evidence that positive changes were being implemented and recorded. Further time was necessary to demonstrate the full impact that the managers would have the operation of the service.
• The management team's knowledge of compliance, legislation and best practice was generally satisfactory. Improvements to their knowledge about robust complaints management and local safeguarding processes would further benefit the service and people who used it.
• Three members of the management team were completing diplomas in the management of health and social care organisations. The registered manager already achieved this qualification. The additional training and learning would assist managers in the good governance of the service.
• There were regular meetings between the management team. We reviewed the minutes from the meetings, and saw various operational and quality improvement topics were noted. The minutes were brief and did not contain enough information to evidence the effective leadership of the service. The minutes also did not contain any actions arising from the prior meeting and whether remedial steps were taken to address them.
• We recommend that the service reviews the recording of management team meetings.

Continuous learning and improving care:
• The registered manager expressed the difficulties the service experienced in implementation of some improvements since our last inspection. They could explain the strategies they used to tackle barriers which prevented the improvements from being made. For example, this included not making some of the planned changes in their action plan and thinking of different methods for improvement.
• The service had experienced a turnover of staff. The management team analysed the reasons why a group of staff had left the employment of the service at a similar time.
• There was a pattern to the staff leaving, but this was beyond the control of the provider. No measures

could be put in place to prevent a recurrence of such an event. The turnover of the staff neither affected the care that people received nor the quality.
• There was some inconsistency of care workers for a short period, but this was promptly remedied and people were satisfied with the staff assigned to support them.
• On reflection, the management team explained what they could do differently next time if they experienced the same event.
• There was a positive workplace culture amongst care workers, the office-based staff and the management team.
• Regular staff meetings were held. All staff had the contact details for the management team and could contact them for any reason, including personal matters.
• The service had employed a massage therapist. Staff could attend the office to have a massage, which promoted wellbeing and a healthy work-life balance. One staff member wrote, "I have been offered a massage today at work by a sports massage therapist…[I] found this helpful to 'loosen up'. Definitely found this to my advantage."
• A staff survey had commenced in November 2018. A limited number of responses were received by the service at the time of our inspection. We advised the management team the survey should be operated on a confidential basis, so staff felt comfortable providing candid responses. The management team were receptive to our feedback.
• All staff were asked to update their health information by the provider. They were sent forms to complete and return to the office. We noted in the two personnel files we examined the forms were not present. The quality and assurance manager explained he would contact the staff directly. The provider was collecting new, updated information to ensure they could make any reasonable adjustments for staff in line with the relevant legislation and conditions of employment.

Working in partnership with others:
• The service had a good working relationship with the local authority and contract monitoring officers.
• The service demonstrated that they worked well with other agencies where needed, for example with the police force. They ensured that they collaborated with other stakeholders to ensure the best possible outcomes for people. The service also provided evidence which showed they worked closely with health and social care professionals so people could lead healthy lifestyles.
• The service had correctly displayed our prior inspection rating in their office and on their website.
• The service submitted relevant statutory notifications to us promptly. This ensured we could effectively monitor the service between our inspections. When needed, the management team provided information to us to help with our enquiries into matters.
• The service used principles from best practice guidance. For example, the managers communicated with staff about the effects of low temperatures on vulnerable adults. They wrote, "Please ensure service users have warm clothing, heating on when required, blankets available if they cannot move about freely unaided, plenty of warm drinks and food." The reminder to staff would potentially prevent people from the development of hypothermia and preventable infections.