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Advance Home Help and Support Services

Inspection report

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Date of inspection visit:
09 February 2017

Date of publication:
13 March 2017

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

This inspection took place on 9 February 2017 and was announced. The service was given 48 hours' notice. This was to ensure that someone would be available at the office to provide us with the necessary information.

At our last inspection on 2 March 2016 we found that the provider was not meeting all the standards that we inspected. We identified breaches of Regulations 17 and 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service did not have effective systems in place to record and monitor the quality and safety of service provision in order to improve, learn and develop. Staff did not receive regular supervision to support them in their role. Staff appraisals were not taking place which meant that staff performance was not being effectively monitored and reviewed. At this inspection we found that the provider had addressed these concerns.

Advance Home Help and Support Services is a domiciliary care agency based in North London which provides care in the community within people's own homes, predominately in Enfield. At the time of this inspection there were 14 people using the service. The service provides personal care, to older people some of whom are living with dementia and or have physical disabilities.

The service had 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.

People using the service and a relative told us that they were happy with the care and support that they received from Advance Home Help and Support Services. People told us that they received care and support from care staff that respected their privacy and dignity and supported them according to their needs and wishes.

Systems and processes were in place in order to protect people from harm. Care staff demonstrated a clear understanding of safeguarding adults and were able to describe the steps they would take in order to protect people from abuse or significant harm. Other procedures that the service followed in order to keep people safe included personalised risk assessments which assessed people's individual identified risks and robust recruitment processes.

The registered manager told us that at present they felt that they had sufficient numbers of staff to meet the needs of the people they supported. In addition the registered manager and deputy manager were always available to deliver care where required. Rotas seen allowed for travel time between each call.

There were suitable and safe arrangements in place in relation to the administration and recording of medicines. The registered manager carried out weekly and monthly audits to ensure that where a person

required support with medicines that this was monitored regularly.

The provider ensured that all staff recruited had received the necessary training to deliver good care. Most care staff had been through the mandatory social care training through previous employments and were able to provide evidence of this. Where gaps in knowledge were identified by the registered manager, appropriate training was organised and delivered. Opportunities were also provided to all staff to develop their knowledge and skills.

Care staff told us and records confirmed that regular supervisions were taking place and that these were an opportunity to discuss any concerns or issues that staff may have and the areas where further support maybe required. Annual appraisals were also taking place which addressed future development and training.

The registered manager and all care staff were able to demonstrate a good understanding of the key principles of the Mental Capacity Act 2005 (MCA) and how these were to be applied when supporting people. People told us that they were supported to make their own choices and decisions where possible. Care staff were able describe ways in which they encouraged and supported people to make their own choices and decisions.

Each person receiving care and support had a care plan in place which was individualised and provided detailed information about the care and support that they required. Each care plan clearly set out the person's needs and the support they required taking into account their wishes, likes and dislikes. Care plans were regularly reviewed and updated as and when required.

The registered manager ensured that details of all communication that took place between people, relatives and the service were clearly documented and held as part of the person's care plan. This also included details of all actions taken by the service in response to the communication which included follow up to medical appointments, financial clarifications and any other issues or concerns related to the care and support that the service provided.

People told us and rotas confirmed that they received care from a regular team of care staff with whom they had developed good working relationships. People and relatives told us that they were treated with respect and dignity. We were told that although staff were present to support people they also encouraged and promoted people to build their independent living skills.

The registered manager confirmed that had not held any team meetings as most staff worked part time for the service and also were in employment elsewhere which made organising staff meetings difficult. However, the registered manager told us that they were always in regular contact with all care staff and were always available to care staff when required. In addition the registered manager planned to develop and produce monthly newsletter as a method of information exchange.

People and relatives knew who the registered manager was and felt able to raise concerns or issues relating to the care and support that they received. They also felt assured that any concerns or issues raised would be appropriately addressed by the registered manager.

A number of quality assurance systems were in place to monitor the quality of the service being provided and to identify any issues or concerns. These included medicine audits, spot checks, regular telephone monitoring, quality surveys and staff questionnaires. This allowed the provider to learn and improve the quality of service provision.

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. People and relatives told us they felt safe and re-assured when receiving care and support from care staff.

Care staff demonstrated a good understanding or how to keep people safe and the actions to take if abuse was suspected.

Risk assessments were in place which assessed people's individualised risks associated with their health and care needs. There was appropriate guidance and direction provided to ensure identified risks were appropriately managed or mitigated.

Safe recruitment practises were in place to ensure that only staff suitable and safe to work with vulnerable adults were recruited.

Is the service effective?

Good

The service was effective. Care staff told us that they were appropriately trained and supported to deliver good quality care. Records confirmed that staff received regular supervision, annual appraisals and appropriate training where required.

Staff received training in specific areas where required. Most of the staff employed by the service were professionals within the adult social care sector had received training from their previous employment.

The registered manager and staff members were knowledgeable on how to assess and monitor's people's capacity to make decisions.

People were appropriately supported to make decisions and choices around the care and support they required.

The service supported people with their health care needs where required.

Is the service caring?

Good

The service was caring. People and relatives told us that they received care and support from staff that were caring and respected their privacy and dignity.

People confirmed they received care and support from a regular team of care staff with whom they had been able to establish positive and meaningful relationships.

People's care plans included detailed information about their likes and dislikes and their preferences.

People's independence was promoted. Apart from supporting people in daily living tasks, staff also supported people to take part in activities and outings.

Is the service responsive?

Good

The service was responsive. People's care plans were personalised and provided detailed information about their choices, needs and preferences.

Records confirmed that care plans and associated documents were reviewed and updated on a regular basis.

People and relatives knew who to complain to and were confident that if they did have any concerns or issues with the care and support that they received that these would be addressed appropriately.

Is the service well-led?

Good

The service was well-led. The registered manager had implemented a number of systems and processes to ensure that the delivery and quality of care and support was monitored and where issues or concerns were identified, these were addressed and where possible learning and improvement measures were implemented.

People and relatives knew the registered manager and were positive about the way in which the service was managed.

People, relatives and staff were encouraged to complete annual quality feedback questionnaires so that the service, based on the feedback, could implement change and improvements in order to be able to deliver high quality care.

Advance Home Help and Support Services

Detailed findings

Background to this inspection

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

This inspection took place on 9 February 2017and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be available to support us with the inspection process.

The inspection team consisted of one inspector and an expert by experience. On the day of the inspection the expert by experience carried out telephone interviews with people using the service and their relatives. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service. The expert by experience spoke with four people and one relative.

Before the inspection we looked at the information that we had received about the service from health and social care professionals, notifications that we had received and the action plan that was sent to us by the provider with details of improvements they planned to make as a result of the previous inspection findings in March 2016.

During the inspection we spoke with the registered manager, the deputy manager and five care staff. We reviewed a range of records about people's care and how the service was managed. These included care plans for seven people, five care staff files and training records, three medicine administration records, quality surveys and a range of policies and procedures.

Good

Is the service safe?

Our findings

People and one relative told us that they felt safe with the care staff that supported them. One person when asked if they felt safe told us, "Certainly." Another person commented, "Yes, most definitely. Both the girls I get are very good." One relative that we spoke with explained, "They [care staff] are very aware that she is prone to falls. They occupy her on walks so she doesn't go on her own. They help her in the shower and she has a special adapted shower so she can sit down and she is safe there."

A safeguarding policy was available to all staff which contained relevant information about the different types of abuse, possible indicators of abuse and the procedures staff should follow in response to a concern or allegation of abuse. The service had not received any safeguarding concerns since the last inspection.

Care staff that we spoke with were able to define the different types of abuse, how they would recognise these and the processes they would follow to report any suspected abuse. One care staff when asked what their understanding of safeguarding was told us, "I would say that is when you are helping them to stay safe." All care staff were aware of the importance of reporting and recording any concerns. Care staff members explained, "Report it to the office and inform the client that you are reporting it and record it in the books" and "Inform the office straight away, it is also important to inform the client so they know what is happening as well. I would then write it all down in the books."

Care staff understood what was meant by the term whistleblowing and were aware of whom any concerns could be reported to, including external organisations such as the Care Quality Commission (CQC) and the local authority.

At the last inspection in March 2016 we found that the service had failed to complete a risk assessment for a person who had been prescribed a blood thinning medicine and was at risk of bleeding if they sustained a cut or injury. The registered manager told us that all care staff had been advised verbally on what to do if this happened but this had not been documented. During this inspection we found that the service had appropriately addressed this concern. As part of the care planning process the service identified and completed personalised risk assessments associated with people's care, health and support needs. Risk assessments identified the potential risk, any recognised symptoms or behaviours associated with the risk and guidance for staff on how to appropriately support the person in order to reduce or mitigate the risk and keep the person safe from harm. Assessed risks included risk of falls, pressure care, equipment, urinary tract infections, fluid retention and risks associated with specific health conditions such as Parkinson's disease, dementia, diabetes and use of blood thinning medicines.

The service also completed generic risk assessments which covered environmental risks, physical health, mental health, mobility, food and diet, housing and health and safety. The assessment again identified the risk or hazard and an action plan had been developed with guidance on how to reduce the risk. As part of the risk assessments the service also assessed all risks associated with any equipment that the person used within the home to aide with their care and support. Equipment included recliner chairs, commodes, perching stools, hospital beds and community alarms. The risk assessments detailed what the potential

risks could be, what staff should look for in terms of potential faulty equipment and how to minimise any risks associated with the use of the equipment. All risk assessments were reviewed on a six monthly basis.

The service recorded all accidents and incidents where people or staff members were involved in an accident. Each accident log recorded details of the person involved in the accident or incident, details of the accident and the actions that were taken. Since our last inspection there had been two recorded accidents or incidents. Appropriate details and actions had been documented with clear information also recorded in the person's daily recording notes so that any staff next attending to the person would be aware of the accident or incident and if any follow up actions were required.

The service offered varying levels of support to people in relation to medicines. For a two people, the service provided full support which included ordering medicines, collection of medicines from the pharmacist as well as prompting or administration of medicines. For any person with an element of support with medicines, the service completed a risk assessment which outlined the level of support the person required and their consent to the support they required. The risk assessment listed the medicines that had been prescribed, the dosage, the times the medicines were to be administered and how the person was to be supported.

We looked at a sample of three people's Medicine Administration Records (MAR) and found that there were no gaps in recording. Each MAR recorded the name of the person, the name of the medicine to be administered and the time, date and signature confirming administration. However, the MAR that was used to record the administration of medicine from a blister pack, did not list each individual medicine that had been prescribed and stated, 'To follow direction and medicines used by pharmacist and confirm number of tablets given.' Care staff were required to confirm and sign the number of tablets that they had administered. We highlighted this to the registered manager and requested that they look at current guidance available about the recording of medicines to ensure that they were appropriately recording the administration of medicines.

Care staff that supported people with medicines received medicine administration training. In addition to the training the service were in the process of introducing medicine competency assessments so that they were assured that staff who were administering medicines were competent to do so. All processes around the overall administration of medicines were noted to be safe and the service ensured that they followed their medicine policy at all times. One relative when asked about the support they received with medicines told us, "Yes, they do. They are quite good at that. They record it after they have given it to her. My other sister knows what she takes as my mum gets confused about it."

People and relatives told us that they received care and support from regular care staff and that staff normally always arrived on time and if they were running late they would receive a phone call informing them that the staff member was going to be late. One person told us, "Yes, if for any reason, they are running late they would call me and let me know so I wouldn't worry about it. I only have two carers who know me and will call me if they are running really late." Another person said, "I don't mind if they are running late I am at home all day so they can come any time. They are not often late, maybe 5 or 10 minutes due to traffic." One relative stated, "Mum says they are here on time and stay as long as necessary and I don't mind. They have been late due to traffic. They always apologise." Rotas that we looked at confirmed that staff were allocated sufficient travel time between calls.

The service had a number of systems in place to ensure the safe recruitment of staff. Five staff files that we looked at contained the appropriate documents confirming that staff were suitable and safe to work with vulnerable people. Documents seen included a criminal records check, proof of identity, proof of eligibility

to work in the UK and two references.

Good

Is the service effective?

Our findings

People and relatives felt confident and re-assured with the care and support that they received from their allocated care staff. They also told us that they found care staff adequately trained and skilled in order to carry out their role. One person told us, "They are sufficiently skilled for what I need. I don't have any real problems and for what they do is sufficient. I could do without the carers but they make my life manageable and someone coming in everyday is not a bad thing." Another person said, "Yes, I do. They always know what to do and I think they do a good job." One relative explained, "Yes, I do. They are well informed about mum's problems."

At our last inspection we found that the staff files did not evidence that staff members were receiving supervision as per the provider's supervision policy. The provider had also not completed annual appraisals for any of the staff team members. The provider sent us an action plan telling us how they would ensure this was addressed. At this inspection, we found that the provider had addressed these issues. We found that all staff members received regular supervision which consisted of a mixture of shadow supervisions and office based supervisions. Shadow supervisions were completed at a person's home where the care staff was undertaking a call.

The supervision looked at punctuality, care plan recording and communication, rights, choice and dignity and emotional support. The office based supervision consisted of discussions with the care staff about the people they were supporting, any safeguarding issues and any training or development required. Staff told us that they felt appropriately supported by the senior managers. One staff member when asked if they received regular supervision said, "Yes, I can whenever I want to. The appraisal seems very good." Another staff member told us, "I haven't had a spot check but they are quite accessible if we need them."

The registered manager and deputy manager had just recently completed appraisals for all staff that had been in employment with the agency for more than one year. During the appraisal topics such as the person's skill set, volume of work, management feedback, training and development were discussed and an action plan was devised based on the agreed outcomes.

The agency did not always deliver an induction or all elements of the mandatory training that each care staff required before starting work as all of the care staff employed brought with them certificates confirming that they had received training and experience through previous or current employment. Some of the staff employed by the service were health care professionals within the adult care sector. The registered manager explained to us that most staff employed by the service had received in-depth training through their own respective professions and brought this experience and knowledge with them to their role.

However, the registered manager ensured that all training was refreshed on an annual basis according to the date they lasted completed the specific course. Staff told us and records confirmed that staff received refresher training in topics including medicine administration, first aid, moving and handling, safeguarding and food safety. Each staff member had a training matrix within their file which listed all the training they had received and the year they completed the training. One staff member when asked if they received an

induction and training told us, "Yes, I don't think they do any training themselves. They do ask to see our certificates from other places to make sure it is up to date." Another staff member commented, "Yes there was one. It helped somewhat to carry out the job."

The registered manager explained that being a small agency it had been difficult to fund a full programme of training including induction. However, they hoped that they would be able to deliver their own customised training package in the future and at present accepted care staff who came to work with them who had previous experience and certificates confirming that they had received training in the last year. The registered manager also told us that they were providing opportunities to care staff who wished to progress within health and social care by organising and registering them to undertake vocational courses offered by training institutes.

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

People and relatives told us that staff always asked them for their consent when supporting them with their care. One relative told us, "Yes she is. They ask her do you want to go for a walk or need a cup of tea." Care plans and supporting documents showed that people or where appropriate their relatives had consented to the care and support that they received. Where relatives held a lasting power of attorney confirming that legally they were able to make decisions on behalf of the person, this was clearly documented. Care plans that were held at the office did not always have a signed consent to care form and we brought this to the attention of the registered manager who confirmed that signed consent to care documents did form part of the care plan held at the person's home but for the future would ensure that a signed copy would be scanned and kept as part of the office records.

The service had a policy in place in relation to the MCA. The registered manager explained that they always assumed people had capacity and care was planned and arranged with the focus on the decisions that people were able to make. Care plans detailed the decisions that people were able to make and the support required. Where people required support with specific decisions such as finance management and medicines, these were recorded within the care plan with details of the relatives involved and the level of support required.

Care staff demonstrated a good level of understanding of the MCA and how this impacted on the care and support that they provided. One staff member told us, "I think it is to ensure people with capacity issues have the rights and access to the same support as everyone else gets." A second staff member stated, "I think that is related to who makes the decision related to a client. I don't have any client that has any problems like that." Care staff explained different situations in which they ensured choice was offered to the person they supported. Feedback included, "When getting them dressed in the morning I will let them pick what they want to wear. I let them choose what they want to eat. I just offer them things", "I will offer people several different options and let them pick what they would like" and "I normally just talking with them and we discuss what they would like to eat or how they want to dress. We discuss everything that we can."

People and relatives generally did not require much support with their meals. One person told us, "No I have a decent system. I have two sons that want to visit me. I have one son that does the shopping, gardening and anything else I need. My boys send through frozen food and they are heated in the microwave." One relative said, "Mum is able to help herself to food. They have helped her when she is not well. She just

needed encouragement to eat as she wasn't eating." If and when people did require support with preparing basic meals or heating up pre-ordered ready meals care staff were able to provide this. The service did support some people with going shopping and ordering meals which were delivered to the person's own home and this was documented within the person's care plan.

Care staff were not always able to monitor peoples food and fluid intake as they were only available at the persons home for a limited period of time and in some instances only once during the day. However, If staff had any concerns about a person's food and fluid intake, these were noted in the daily record notes and highlighted to the registered manager and or family members.

People and relatives confirmed that they were supported with their healthcare needs when required. One person told us, "If I am feeling poorly the girls [care staff] will phone my daughter and let her know." The service supported people with health and social care appointments where required. Where people were supported to attend appointments, the service kept clear logs of the appointments and the outcomes of these appointments so that these could be handed over clearly to relatives who had been unable to attend.

Care staff were clear on the actions they would take if they had any health concerns about the person they were supporting. One staff member told us, "So far, I have had no problems. But I would talk to the client and if it was an emergency ring 999 and tell the office to contact the next of kin." Another staff member said, "I would talk to the client and if needed the next of kin and inform them what I think is happening. I would also inform the office and tell them I was worried about this."

Good

Is the service caring?

Our findings

People and relatives were happy with the care and support that they received and stated that carers were caring and were part of their family." One person said, "Yes. The fact that they come and prepare a meal and get me dressed is very good and they also do a few things more than they need to. Overall I am very pleased." Another person stated, "Yes very caring. I don't know they just do anything for you. They are like family." One relative when asked if staff were caring said, "Yes, I do. Everything they do is wonderful."

People and relatives confirmed that they received care and support from a team of regular care staff with whom they had established positive and caring relationships. One person told us, "I've never tried to change them [care staff]. The ones I have are good."

The registered manager told us that she visited people at a minimum on a weekly basis to ensure that the person was happy with the care and support they received. Alongside this the registered manager also regularly maintained telephone contact with each person or their relative so that care and support was delivered cohesively and in partnership with all involved. We saw records that the registered manager kept of all communication that she had with people and their relatives.

People and relatives confirmed that they were involved in the planning of their care and support needs and that their choices and wishes were taken into account when the package of care was agreed. One person told us, "Yes, they discussed my needs with me." Another person said, "Yes, before I moved in we had a meeting and we discussed what I needed." One relative said, "I was not, but my sisters were." Care staff also told us about how they ensured people and relatives were involved in the delivery of their care. One staff member told us, "I am always asking the clients what they would like or if they needed anything different. I like talking to my clients." Another staff member said, "I always try talk to my client and keep them at ease and discuss their views. The office speaks to relatives and they have some meetings I think."

People told us that the care staff that supported them did so with dignity and respect and always ensured that their privacy was maintained at all times. One person told us, "Yes, when bathing it's done in a very good way. Overall I can't fault it." Another person said, "Yes, the way they talk to you and listen. They really care."

We asked care staff about how they ensured people's privacy and dignity when delivering care and support. Comments included, "When washing them they are in the bathroom privately and make sure they are washed bit by bit and used a lot of towel to cover them up and keep them warm. You respect what they want and just treat them with dignity. Just treat people the way that you want them to treat you" and "The way I talk to clients is always respectful. I try and make sure that when showering the doors are closed and only cover uncover small parts of the body at a time. I also make sure afterwards they are dressed smartly and sometimes help them put on makeup."

At the time of this inspection the service did not currently support anyone with end of life care. The service was able to show us the documentation that they had available which would be completed if a person was

assessed as requiring end of life care. The end of life care plan covered the person's health conditions, possible complications arising from their poor health, specific instructions on how the person was to be supported with their care such as oral hygiene and skin care, details and contact details of health care professionals, relatives and friends who were involved with the persons care and any particular requests or advice relating to the provision of care. The care plan also recorded if the person had 'do not attempt cardio pulmonary resuscitation' documentation and a copy of this was retained by the service.

Good

Is the service responsive?

Our findings

People and relatives knew how and who to complain to if they had any concerns or issues. One person told us, "I would talk to [name of manager]. She is excellent." Another person said, "[Name of manager] she is wonderful, I think she would do whatever she could." One relative said, "Yes, in the first place I would phone the agency and if we were not happy with that we can go to the quality care commission [CQC] people."

The service had a complaints policy in place which outlined the processes involved if someone wanted to raise a complaint. The policy also outlined contact details of other external agencies that could be contacted if the person or relative was not satisfied with the agencies outcome and response to their complaint. The service had a complaints book which listed one complaint that had been received since the last inspection. The record detailed the nature of the complaint and the actions the service took to resolve the complaint.

The service carried out pre-service assessments which identified and captured people's care and support needs, background information about the person and their life as well as their health and medical history and details of the key people involved in the person's care. Based on the information obtained, a personalised care plan was developed and provided information in areas including, night care, mental and emotional needs, physical health and mobility needs, pressure care, clients and next of kin wishes. The service also produced a brief overview which was held within the care folder at the person's home and contained directions on what care staff were required to do at each call, a list of activities that people could participate in and shopping lists where this was a required element of the care package. Records showed that care plans were reviewed and updated regularly and as and when changes were noted. Reviews undertaken discussed the current package of care, mobility concerns, medicine management and recorded actions that were required to be taken as a result of the review.

Care plans were individualised and person centred and detailed key pieces of information about the person, about their life, their choices and wishes, likes and dislikes, needs and requirements with a focus on the person's abilities and how these were to be maintained. One care plan stated, "[Name of person] will cook vegetables with supervision" and "She likes football and [a specific television show]."

Care plans were designed and written to promote independence to ensure that people were encouraged and supported to achieve this. Care staff demonstrated a good understanding of how to maintain people's independence and gave some examples. One staff member explained, "When I help the person with dementia I try and get her involved and ask her to help out as much as she can with things like washing or little bits in the kitchen." Another staff member said, "I encourage them to do things on their own first and if they are stuck I will give them a hand. I try and make sure they are doing something they enjoy. If they are feeling poorly or just don't want to do anything I will do it all for them but my clients enjoy helping out." A third staff member told us, "One of my clients I take for a walk just outside up and down but it helps her to get out."

Care plans documented specific information about people's likes and dislikes and health care needs. This

included their choices and wishes about the food they liked and disliked as well as any health, religious or cultural requirements where appropriate. One care plan we looked at recorded, "[Name of person] can indicate her wishes so ask what she would like for breakfast. Ask her if she would like a hot chocolate, a sherry or a glass of water left by her chair for the evening." The same care plan also recorded specific foods the person was to avoid due to the medicines they had been prescribed where possible adverse reactions were possible.

The service, as part of the package of care also provided opportunities for people to partake in activities and outings where possible. We saw records confirming a variety of outings that the service had supported people with which included visiting the hairdressers, shopping, weddings, pub visits and going out for dinner. The service owned a wheelchair adaptable vehicle in which they could support people to access the community.

Daily records were completed by care staff for each person they supported. Information that staff recorded included the date, time and duration of the call, the tasks completed, what the person ate, if medicines were administered and taken and any other significant information related to the care, support and health needs of the person. This ensured that if another staff member was to attend to the person at the next call they would have a clear handover about the person and if there were any concerns or issues to be noted.

Care staff demonstrated a good understanding of what person centred care meant and were able to explain how this could be achieved. When staff were asked about their understanding of personalised care, comments we received included, "I understand that it's a care plan made for that individual to meet their care needs. Ask them what they want and what they need. Just making sure their needs are met in everything", "It's related to care plan and make sure it's related to one person and meets their care needs" and "It's individual care based on the needs of the client. Things like helping the client go for a walk."

The service kept records of all compliments that they received. One relative had written, "I would like to praise [name of care staff] for her efficient and wonderful caring ways with [name of person]. She went the extra mile in every way to make [name of person] feel comfortable, content, cared for, special and less lonely."

Good

Is the service well-led?

Our findings

People and relatives told us that they knew who the manager of the service was and felt able and confident to raise any concerns or issues that they had. When asked if people knew who to speak with if they had any concerns and whether they were confident these would be addressed, comments we received included, "Yes, I think she would" and "As I said before I would talk to [name of manager] and yes, she would take it seriously."

At the last inspection we found that the provider was in breach of Regulation 17 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 as the service did not have effective systems in place to record and monitor the quality and safety of service provision in order to improve, learn and develop. During this inspection we found that as per the provider's action plan, this breach had been met. The provider had introduced a number of quality assurance systems to monitor and improve service provision which included weekly and monthly medicine management audits, regular spot checks of care staff whilst providing care, care plan checks as part of the review process, audits of daily record notes and medicine administration records and the implementation of satisfaction surveys for people, relatives and staff members.

Records confirmed that people and relatives had completed annual satisfaction surveys which asked for feedback on the quality of care and support that they received. Questions asked focused on whether the person's needs were being met, do staff arrive on time, quality of the service and if there were any improvements that could be made. For 2016, five questionnaires were completed and returned out of the 14 that were sent out. We saw that the registered manager had completed an analysis of the survey which included learning points that they had been able to identify from the completed surveys. For example one person had made comment about lateness and being informed by the office when staff were running late. The service stated that this would be an area that needed to be re-emphasised to care staff to ensure they communicated effectively if and when they were running late.

Where annual satisfaction surveys for people, relatives and staff members had been completed, the service had collated the information that they had received and had completed an analysis of the results with recorded learning points derived from their findings. The registered manager told us, "We want the emphasis to be on the quality of the service. We do not want it to grow so big that we lose sight of that quality." The registered manager also had systems in place which allowed senior managers oversight of when supervisions, appraisals and training were due for each staff member to ensure that staff were supported appropriately and regularly.

The service monitored all lateness and missed visits and recorded these with details of the actions taken. We saw that the service had incurred three missed visits in the last year. However, these had been due to management miscommunication and errors on the staff rota. We saw that the management acknowledged and apologised for their mistakes with the person and relatives who it had affected and had ensured extra checks of rotas were in place to ensure that these mistakes were not repeated.

As part of monitoring the rotas, the registered manager sent all care staff their rotas a week in advance and where people or relatives had a requested a copy of the rota this was hand delivered to them again a week in advance. This allowed for care staff, people and relatives to identify any mistakes or concerns with the rota so that these could be rectified in advance.

The registered manager told us that they had not held any staff meetings since the last inspection. This was due to the fact that the care staff team was relatively small and because mostly all staff were part time and were also in other employment, it had been difficult to bring them all together. However, the registered manager confirmed that they were regularly in touch with all care staff which consisted of weekly visits to all the people they supported as well as follow up calls with care staff if any concerns or issues were noted.

At the last inspection the registered manager had told us about producing a newsletter for the care staff team so all important and pertinent information would be communicated to all staff on a regular basis. This had not taken place but the registered manager showed us a sample of a newsletter that was currently in production which was due to be distributed by the end of March 2017.

Care staff spoke positively about the registered manager and deputy manager and confirmed that support and advice, in order to carry out their role, was always available. Feedback from staff about the managers included, "Yes there is always someone there any time of the day. They are pretty good on that front", "Yes very much so. If I have are any problems I can ring the office and there's always some there to help answer any of my questions", "I think she [registered manager] is very dedicated to the job she makes it so some people are almost pampered", "We have two managers and both of them are very good and helpful, I have had no problems with them" and "They [managers] are always available to talk to you if you need them. They try their best in to help me in anything I need."