Leeds Jewish Welfare Board

Moorcare

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?	Requires Improvement

Summary of findings

Overall summary

A comprehensive inspection took place on 15 and 16 August 2018 and was announced. The service is managed and owned by the Leeds Jewish Welfare Board. Moorcare is a domiciliary care agency providing personal care to people living in their own homes in the local community and surrounding areas. The service supports older people and some younger adults. At the time of our inspection the service was providing care and support to 60 people.

Not everyone using the service received regulated activity; Care Quality Commission (CQC) only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do, we also take into account any wider social care provided.

At the end of 2017 there was some change in personnel, with the previous registered manager and some office staff leaving. At the time of our inspection, a manager was in charge of the service. 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. Following our inspection, the chief executive told us they had appointed a permanent manager and they would be registering with the CQC in due course.

Following the last inspection, we asked the provider to complete an action plan to show what they would do and by when to improve the key areas of safe, effective and well-led to at least good.
At that inspection the provider had not taken appropriate steps to ensure staff supervisions had been completed in line with their policy, and Medication Administration Records (MARs) had not been fully completed. Policies and procedures were not up to date and were disorganised, documentation had not been completed for people who may lack capacity to make decisions and not all staff had completed Mental Capacity Act (MCA) training. Quality monitoring arrangements were not robust. At this inspection we found the service had made some improvements, although some further work was still required with the accuracy of information recording.

A quality assurance process was in place; however, the audit process was not fully robust and further work was needed to strengthen the consistency of information in people's care plans and the accurate recording of support and management documentation. The manager and chief executive told us there were aware of this and in the process of strengthening the auditing process.

Medicines management systems were in place to ensure people received their medicines at the right times. However, the administration of people's medicines was not always appropriately recorded. People told us they there were happy with how they received their medicines. When necessary staff involved GP's or the emergency services to make sure people's health care needs were met.

Staffing levels were appropriate to meet people's care and support needs, although there were mixed views

on the consistency of staffing. Recruitment processes and checks were in place and followed, to reduce the risk of employing staff who may not be suitable to work with vulnerable people.

Staff completed a range of training and had opportunity for on-going development. Training was monitored and refreshed in a timely way. Staff received supervision on a regular basis, although the chief executive told us some staff appraisals were overdue. New employees received an induction which included, training and shadowing a more experienced staff member.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice. Some people had mental capacity assessments in their care plans. Staff understanding of MCA needed to be strengthened.

People who used the service told us they felt safe with the staff and the care they were provided. Staff understood how to recognise abuse and there were appropriate systems in place to protect people from the risk of harm.

Staff had access to personal protective equipment and had completed infection control training.

People told us staff were kind and caring and they were very happy with the service they received. Staff treated people with respect and took steps to maintain their privacy, dignity and independence.

People's individual dietary needs and preferences were being planned for and met, where required.

Care plans were person centred and reviewed when required. People and staff were mostly complimentary about the manager. They said they were approachable and listened. There was a complaints procedure in place which enabled people to raise any concerns or complaints about the care or support they received.

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 told us they were happy with the staff support they received with their medicines. We found some minor concerns with how staff recorded medicines administration.

Staff knew how to recognise and respond to abuse correctly. Risks had been assessed and identified action had been taken to mitigate those risks. Infection control procedures were in place.

Staffing levels were sufficient to effectively meet people's care and support needs. The staff recruitment process was robust.

Is the service effective?

Good

The service was effective.

Staff received an induction and training appropriate to their job role, and had regular supervision. The chief executive told us they were behind with some staff annual appraisals.

People who used the service told us they were always offered choice. Care plans contained a mental capacity assessment, where needed.

People's nutritional and healthcare needs were met, where appropriate.

Is the service caring?

Good

The service was caring.

People were happy with the care and support provided. Staff used their knowledge of people to deliver person centred care.

People's privacy and dignity was respected.

Staff involved people and/or family members in the care planning process.

Is the service responsive?

Good

The service was responsive.

People had care plans in place which were mostly reflective of their care and support needs. Some records needed to be more consistent. People's communication needs were recorded.

The chief executive worked with community partners to provide social and community activities for people. People were provided with information about how to raise a concern or make a complaint.

The service did not currently support anyone who was approaching the end of their life.

Is the service well-led?

Requires Improvement

The service was not always well-led.

Some quality assurance procedures were in place; however, these were not robust. Record keeping in relation to care and support required improvement.

People and staff were mostly positive about the manager. The manager was not registered with CQC at the time of our inspection. There was a system in place to gain feedback from people, relatives and staff.

Moorcare

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 comprehensive inspection took place on 15 and 16 August 2018 and was announced. We gave the service 24 hours' notice of the inspection because we needed to be sure the manager would be available at the office. The inspection was carried out by an adult social care inspector, an assistant inspector and two experts 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. The experts by experience had experience of domiciliary care agencies and completed telephone interviews on 16 August 2018.

We used information the provider sent us in the Provider Information Return (PIR). 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.

Prior to the inspection we reviewed the information we held about the service and requested feedback from other stakeholders. These included the local Healthwatch, the local authority safeguarding team and local authority commissioning and contracts department. Healthwatch is an independent consumer champion that gathers and represents the views of the public about health and social care services in England.

Inspection site visit activity was completed on 15 August 2018. We visited the office location to see the manager and office staff. We spoke with the chief executive, the manager, the quality assurance manager, training manager, six staff members and 15 people who used the service to obtain their views. We looked at six people's care plans. We inspected three staff members' recruitment records and four staff members supervision, appraisal and training documents. We reviewed documents and records that related to the management of the service, including quality management records, audits, risk assessments and policies and procedures.

Good

Is the service safe?

Our findings

At the last inspection we rated this key question as requires improvement. We concluded, at the inspection in July 2017, the provider had not taken appropriate steps to ensure the management of medicines was safe. We issued a requirement notice as systems in place did not ensure people received their medicines as prescribed. At this inspection we found the provider had made some improvements, but further work was required to make sure the recording of the administration of medicine was robust, which we have referenced in the well led section of this report.

People we spoke with were happy with the support they received with taking their medication. One person said, "They (staff) do help me with my medication because my family have said I can't be relied on to take them myself. The chemist sends everything in a packet marked for every day."

Most people's medicines were provided pre-dispensed in blister packs from the local pharmacist, which minimised the risk of errors being made.

We reviewed the medicine administration records (MARs) and saw there were some gaps in the recording of administration, especially for topical creams had not been completed appropriately.
The chief executive told us they were aware of this issue and had implemented new MARs, from August 2018, which would support better staff recording. We spoke with the quality assurance team who told us they had completed a medication audit in May/June 2018 and this had highlighted recording concerns. Immediate actions had been taken to address this with individual staff.

The provider had policies and procedures relating to the safe administration of medication, which provided guidance for staff to follow. The training records we looked at showed staff had completed medication training in 2018. One staff member said, "We have just all had a refresher course and I had a spot check. She (supervisor) just turned up to see what I was doing, watched me, chatted to me, chatted to my lady. Everything was fine." Records confirmed that 'spot checks/medication observations' and medication competency checks had been completed for some staff.

People we spoke with told us they felt very safe with the care staff. Comments included, "I feel very safe with them. I wouldn't have a wrong word said about them. It's not an easy job they do but they are very conscientious. They are lovely people and I feel safer just by having somebody come every day", "I feel very safe with the carers. I have absolutely no worries at all about safety. If I want to do something for myself like getting dressed, they let me do it but will be ready to steady me if needs be" and "I feel safe. I can talk to her (staff member)."

Staff we spoke with had a good understanding of safeguarding and were able to confidently describe what they would do should they suspect abuse was occurring. One staff member told us, "I provide the best care possible in a safe manner and follow procedures. My first port of call would be my manager or supervisor." Staff had received training in safeguarding adults in 2018 and we saw safeguarding and whistleblowing policies were available.

Staff we spoke with told us they had received training in moving and handling and the use of equipment. One staff member said, "If they have got support equipment, I make sure they use them." Another staff member told us, "I have had hoist and overhead hoist training which was practical training. I am fully trained."

Risks to people's health and safety were assessed. People's care plans contained a generic risk assessment regarding the person's home, for example, pets, kitchen equipment and the heating system. Care plans identified risks relevant to the person's care and support needs. For example, infection control, manual handling, fire, eating and drinking and tissue viability. We saw one person had a risk assessment in place for moving and handling and this recorded sufficient detail to reduce the risk of harm to the individual or staff. Care plans also contained staff training requirements for each individual person, to reduce any risks. For example, where staff were required to prepare food, they had completed food hygiene training.

The manager told us financial transactions sheets were in place if the staff spent money on behalf of people who used the service and confirmed these were checked by office staff.

People told us that where they had regular staff members, they knew them well. One person commented, "I had the service a long time ago and then I always had the same regular carers but now I never know who is coming. They do send me a rota, but it would be nice to have the same person even if only for two or three days together. It takes me a while to get to trust people and feel safe with them." Another person said, "Routine is very important for me. I didn't have a regular team for a long time." The manager and chief executive were aware of this and were currently recruiting new staff members to support consistency of staff.

Staff told us there were generally enough staff to provide care and support for people and they had enough time to complete each visit and to get to the next visit. One commented, "I think things seem to be improving. We've recruited a few more (staff)."

The manager and chief executive told us sufficient care staff were employed for operational purposes. The chief executive said that following a change in the management team and office staff they had recruited new staff to specific posts, including care co-ordinators, supervisors and field staff. The manager explained they used an electronic rota monitoring system which enabled them to monitor that staff had arrived at care visits as scheduled. They used smart phones to send messages between the office and the staff. This showed reoccurring schedules, monitoring of call times and length of stay. They said any gaps in rotas were filled by Moorcare staff, bank staff or agency, but the use of agency staff had reduced following recent recruitment.

The manager told us they used a 'matching' process to make sure people and staff were suited. This included looking at which staff member was available, personality and skill level. The manager said they arranged a 'meet and greet' session as part of the introduction process with the person and staff member prior to care and support being provided.

Safe recruitment procedures were in place to ensure only staff considered suitable to work with vulnerable people were employed. We saw appropriate checks had been made, including a Disclosure and Barring Service (DBS) check and at least two written references were obtained before new employees started work. The DBS checks assist employers in making safer recruitment decisions by checking prospective staff members are not barred from working with vulnerable people.

Staff had completed infection control training in 2018 and there were policies and procedures in place to guide them. During our inspection we noted staff were able to call into the office to collect a supply of

personal protective equipment (PPE) such as gloves and aprons.

The manager and chief executive told us they had learned lessons through management changes and complaints they had received. Also, they had changed some documentation as a result of the last CQC inspection. For example, contact details forms, concern reports and one-page profiles had been introduced, along with changes to MARs. The chief executive said information was shared across monthly meetings.

Good

Is the service effective?

Our findings

At the last inspection we rated this key question as requires improvement. We concluded, at the inspection in July 2017, the provider had not taken appropriate steps to ensure people's care plans evidenced compliance with the Mental Capacity Act 2005 (MCA) and not all staff had received supervision. At this inspection we found the provider had made improvements.

People told us, in general, staff were well trained and knew what they were doing.

Staff told us they received appropriate training to deliver care and support. One staff member said, "I have done medication and moving and handling. I have done catheter care with [name of trainer] and a district nurse came in and I have done PEG (percutaneous endoscopic gastrostomy) feed training."

We saw from the training matrix staff training was up to date. Training included topics considered mandatory by the provider, such as health and safety and fire safety. Specific staff training was delivered in line with the needs of people they supported. For example, PEG feeding. The service had a dedicated staff member who provided and monitored all staff training. They told us they had a system in place to monitor when training had expired. This showed us staff were receiving appropriate training and were being supported in their roles.

Staff we spoke with said they had regular supervision and an annual appraisal which gave them an opportunity to discuss their roles and options for development. Comments included, "Yes, we get supervisions. I've had one not long since. We can speak about any concerns" and "They listen to what I'm asking. I feel supervisions are good, you have got the time to go through how you are feeling. I must admit, I do feel supported by them all." Staff files and records we looked at showed staff had received supervision and/or 'spot checks' in 2018.

We saw new staff completed an induction and the trainer told us new staff were allocated a more experienced staff member to act as their mentor. One staff member said, "I shadowed for two weeks with different people." The induction included completion of the Care Certificate modules and practical training. The induction checklist also included information about the organisation, timesheets, lunch breaks, staff handbook and Jewish culture and traditions. The Care Certificate is an identified set of standards that health and social care workers adhere to in their daily working life.

The provider's PIR stated, 'Our new care plan assessment considers our service user's preferences, religious and cultural backgrounds' and 'Our in-house Kosher catering service for people who wish to have a 'supervised' Kosher meal. This service can provide a range of specialist meals including frozen meal delivery and 'Lunch for Less' at lunchtimes'.

The manager told us office staff had a morning handover to review any concerns raised over night and any action required that day. The office was now staffed on a weekend and until 10pm each night, enabling staff who only work these hours the opportunity to go into the office.

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 so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. For people supported in the community any applications to deprive a person of their liberty must be made to the Court of Protection.

We checked whether the service was working within the principles of the MCA. People we spoke with told us they were offered choice by the care staff. One person said, "I think the carers are marvellous. I make all my own decisions and if they are doing anything for me they constantly ask if it's alright. I have freezer meals at lunchtime and they will fetch a selection out for me to look at to decide what I fancy."

Staff understood their obligations with respect to people's choices. Comments included, "I ask them what they would like. If they would like a shower, if not, a strip wash. Choice of meals, choice of what they would like to wear. Even down to where they would like to sit", "I would ask them what they would like for lunch. It is allowing them to let you know what they want instead of just presuming. You can do that without realising. It is wrong" and "I ask them, I give them choice."

Some staff we spoke with were unsure about the meaning of the MCA. The chief executive told us they had introduced 'flash' cards on the MCA to support staff learning, but would also reiterate this through communication with staff.

When we asked the chief executive if they used any current legislation, standards or evidence-based guidance to achieve effective outcomes for people, they told us they referred to CQC information, updates from Leeds City Council, the working age and the Jewish social care forums. They went on to say, where required, all the provider's policies and procedures referred to relevant guidance. For example, the medication policy referred to the Medicines Act 1968 and National Institute for Health and Clinical Excellence (NICE) guidance.

Where identified as part of someone's care plan, people were assisted to maintain their nutritional and fluid intake. Care records showed where people required support with preparation of meals.

The chief executive told us some people were supported with specific dietary needs due to their religious beliefs, cultural heritage or likes and dislikes. We saw this was reflected in the care plans we reviewed.

There were procedures for staff to follow should an emergency arise in relation to the deterioration in the health or well-being of a person who used the service. Staff we spoke with told us they would also report changes in people's health care needs to the manager. One staff member said, "I would contact the office. They would come out and see what needed changing on the care plan."

We found people who used the service or their relatives usually dealt with healthcare appointments, although the manager told us they did sometimes arrange and/or escort people to GP, dental or optician's appointments for people, when needed. Staff commented, "I phoned the office to see if I could get [name of person] a GP appointment. I got one more or less straight away, they were very good" and "I have taken people to hospital appointments."

Good

Is the service caring?

Our findings

People told us staff were kind and compassionate. Comments included, "I can't fault the carers in terms of kindness. It doesn't matter how busy they are, they will always make time to have a little chat and listen to me", "They make my day really. When you live on your own it can get a bit lonely and sometimes I do feel very low. Every single one comes in with a smile and I end up having a laugh with them. It makes all the difference to me", "The carers really go the extra mile all the time" and "They (staff member) are like a member of my family."

We saw compliments had been received into the office which included, 'A huge thank you to all the girls who looked after [name of person] over the past few weeks. We so appreciate the love, care and attention'.

The service supported people within a seven-mile radius of the office and staff rotas were organised, where possible, to allow people to have the same staff members. The manager said new staff were always introduced to people prior to them working with the person.

We found the chief executive, manager and staff to be motivated and enthusiastic about making a difference to people's lives. We asked staff how well they knew the people they supported. Comments included, "[Name of person] likes a lot of milk in their coffee and always likes the cup stood on a square piece of paper. By going to people regularly, you get to know what they like and don't like", "I get to know them, I ask questions. I take it in and listen very well to what they like. I'm very interested. I know their dislikes and likes. We have a giggle and a laugh" and "[Name of person] likes crumpets every morning for breakfast, a cup of tea with no sugar but I always give them the choice anyway."

Care plans showed people, and their relatives when appropriate, had been involved in their development. We saw some people had signed their consent to care and support, consent for information to be shared and terms and conditions of the service. Some people we spoke with could tell us about their care plan reviews. This meant people were actively involved in decision-making about their care and support.

Information about what people were able to do for themselves and what they needed support with was included in the care plans. For example, one person told us, "The carers who come are brilliant. They are very careful. I use my Zimmer frame because I do like to try and do things for myself, like getting washed, but they are always standing by ready to hold me if they think I'm getting unsteady." Another person said, "One of the carers who comes definitely needs some kind of award. She is just brilliant. I think she is the very best they have got. I am registered blind, so I need a bit of extra help with things I like to do. I do some colouring when I am at home and they will make sure I have got things where I can find them easily."

People said staff were kind and polite and observed their rights and dignity. They told us staff knew what they were doing and were respectful and helped them to remain independent. Comments included, "They (staff) are just amazing. Brilliant. They will always wash my hair because I can't do it myself and they make sure I'm properly dried afterwards", "[Staff member] is very respectful" and "They (staff) are lovely, caring, helpful. They do things with respect and dignity."

Staff told us they would always ensure people were covered up when delivering personal care and where needed, the curtains or blinds were closed. They told us they supported people's independence where appropriate. Comments included, "I make sure [people] are covered. When we go to the bathroom, I make sure the door is closed. I don't discuss anybody else. You don't discuss things with other carers or neighbours" and "I would go out of the bathroom and give them time and then knock at the door to see if they're ready for me to go in." Other staff told us, "I always say, 'excuse me' when bathing them. You just have to be respectful of people. I always say I hope I get a carer like me when I'm older" and "When moving people from the shower room, I make sure there is a towel covering them."

The chief executive was aware of referral procedures for advocacy services and had access to information on advocates in the local area. This was made available for people, if needed.

They told us a part of the staff induction was to make sure staff understood the Jewish and other faiths and culture and when Jewish celebrations and key events were. They said they supported people to access religious venues when required. We saw people's care plans recorded their cultural/ethnic background, religious preferences/spiritual belief system, preferred language and religious needs. The service had an equality and diversity policy and staff received training in this subject.

Good

Is the service responsive?

Our findings

Before people started using the service, the manager assessed their care needs and discussed with them how the service could meet their needs, wishes and expectations. Care plans were developed, with the person and/or their relative, to agree how they would like their care and support to be provided. One person told us, "They came and talked to me about what I needed but it is a long time ago now. They said that if I need more support they can come and review things with me."

We asked staff how they were kept informed of people's needs and if they read people's care plans. Comments included, "I would go in and read the care plan. Things can change hour by hour, not week by week", "I would probably get a telephone call updating me and I would read the care notes, to see if things have changed" and "I read them as I go. I have got time and because I'm going to regular clients, you know what's what. Things do change, you cannot take it as it being the same tomorrow."

The manager told us a copy of the care plan was kept in the person's own home and a copy in the office. We saw care plans were reviewed annually, or sooner, if people's needs had changed. Care plans contained details of people's routines and information about their health and support needs. This information was important to enable staff to deliver person centred care. For example, one person's morning routine included, '[Name of person] likes his coffee black, with one and a half sugars.'

We noted some information in care plans was not consistent. For example, one person's social and personal assessment stated 'religious/spiritual belief system' was 'none' and, the cultural/religious needs and preference section stated 'prayer/sabbath times'. We brought this to the attention of the manager and chief executive who said they were in the process of reviewing care plans and would address this.

The chief executive told us they were looking to forge links with local community groups and identify organised activities that people may wish to be involved in, such as taking part at the community centre where the office location was. One person told us, "I like to get out and about as much as I can. I go to a day centre where I do painting and colouring and sometimes get my nails done there. I'm learning to do cross stitch and they (care staff) ask to see what I'm doing. It's nice that they take an interest in things like that. I feel as though they are friends of mine." We concluded the provider was providing social and recreational support for people, where required.

We looked at the complaints records and saw there was a system in place to make sure any concerns or complaints were recorded, together with the action taken to resolve them and the outcome. Staff we spoke with told us people's complaints were taken seriously and they would report any complaints to the manager. They felt comfortable to report poor practice to the manager. The manager and chief executive said people's complaints were fully investigated and resolved to their satisfaction wherever possible. This showed people's concerns were listened to, taken seriously and responded to promptly.

People told us they were aware of how to raise a concern or complaint. Comments included, "I don't want to write a complaint. I know they are trying", "The manager does not reply every time. I have to call and make

sure they received my message" and "If anything was going wrong or bothering me, I'd talk to the main carer who comes here first because she's really good. I feel comfortable talking to her." The manager told us they were in the process of improving communication throughout the service.

The manager and chief executive told us, currently, the service did not provide care and support for people whose primary need was for end of life care. Some staff we spoke with could describe how they would support people at the end of their life. For example, one staff member said, "It means making sure they are comfortable. Their mouth is clean and repositioning to prevent them from getting sores. Working alongside the district nurses and other carers. Documenting any concerns and reporting back. Talk to them to make sure they are comfortable."

The Accessible Information Standard came into force in 2016 with the aim of ensuring people with disabilities, impairments or sensory loss get information they can understand, plus any communication support they need when receiving health and care services.

People's care plans contained information about their sight and hearing, and any aids they used. They contained details the way people communicated and asked if they had any communication requirements in terms of, for example, English not being their first language. We saw one person's care plan written in a different colour to black, which aided the person to be able to see the content. Documentation was available in easy read format. This showed the provider was working in line with the Accessible Information Standard.

Requires Improvement

Is the service well-led?

Our findings

At the last inspection we rated this key question as requires improvement. We concluded, at the inspection in July 2017, the provider had not taken appropriate steps to ensure audits were effective and policies and procedures were not up to date and were disorganised. At this inspection we found the provider had updated their policies and procedures and some improvements to the audit process had been made but further work was required to make sure these were effective and robust.

We spoke with the quality assurance manager who told us there was a schedule of audits in place with specific areas of the service audited each month. For example, in June 2018 MARs, complaints, care plans and client daily notes were audited. We looked at the overview of the MAR audit for June 2018 and saw this had identified there was ongoing inconsistency with staff signing MARs. The quality assurance manager told us feedback meetings had taken place with individual staff members and actions had been identified and a plan to address these had been created. They acknowledged the audits still required some further strengthening and embedding and told us they were working pro-actively to improve this.

Staff told us they worked well as a team and found their supervisor supportive. Comments included, "They're all nice as well. If you've got anything, you can always go to them" and "[Name of staff member] is great. They have been out in the field as a carer and they follow things up when I have reported things. That is what you need. A good team to support us."

Record keeping at the service required some improvement. Care plans had been audited in February 2018 and an action plan was in place. However, in one person's care plan, following the audit, we identified conflicting information as to whether the person required prescribed creams applying. At this inspection we found this was still the case. Some areas of people's care plans did not provide consistent information. For example, one person's care plan for desired outcomes, stated, 'I have history of falls and very anxious about falling'. However, the moving and handling risk assessment did not refer to the person being at risk of falls or the person's falls history.

The manager told us they were behind with some staff annual appraisals and we saw a mental capacity assessment required reviewing to make sure all information was accurate and complete. We noted some improvements from the last inspection had been implemented and further work was ongoing to make sure improvements with recording information was sustained and fully embedded.

Records showed the registered manager had systems in place to monitor accidents and incidents to minimise the risk of re-occurrence.

Some people we spoke with told us they were happy with the service and no improvement was needed. Comments included, "I can't think of any improvements they could make. All the carers and everyone involved gives me a bit of support. I can always get through to the office, although I don't usually have to bother because the carers will pass on any messages" and "I feel very well looked after and very safe. The people in the office are always very nice too."

People we spoke with told us the management of the service was getting better. Comments included: "I have been with this service for a long time and things were not very good when they had a different manager a while ago, but it is getting better now. I feel a lot happier than I did and I think the carers are happier", "The service has much improved." and "Things are going better now. I know it takes time. In the past they messed about." One person told us, "They are trying but messages don't get through. They are on a computer system. They rely on it so they are not checking, they don't do follow-ups. I have to double check with them." The manager told us they were evaluating the computer system they used to make sure the correct information was being provided.

The manager told us they used various methods to obtain people's views of the service. These included questionnaires, manager visits, telephone monitoring and an annual forum. We saw the results of the January to July 2018 client questionnaire and monitoring report, which showed people were happy with the service they received. We saw actions had been identified, which included, making changes so communication was more effective.

Staff we spoke with told us they enjoyed working for the service and found the manager to be helpful and approachable. Comments included, "The manager] is nice, she knows what she's doing. If you've got any questions, she'll sort them out for you. She's good with us as carers. If we've got any problems, we can go to her. I enjoy what I do. I enjoy going to people and seeing the satisfaction. I love it. They're all different" and "I think she's doing well. I've seen a change. Especially this last four weeks. I think she's bringing the company forward. I enjoy helping people. Making sure people are safe in their own homes."

When we asked staff if they attended meetings or were able to contribute to the running of the service, we received mixed views. Comments included, "Yes, we do. We don't have them that regularly. The office will ask us, if they have got new ideas, if we could improve it any way. We get an input", "No, not recently. But in the past, I do believe we have been asked for feedback" and "I haven't been for a staff meeting for a while." Others said, "They have asked for feedback from us in email and verbally" and "No, we don't really have staff meetings, but I always have input of what I think should go in place, whether that happens or not, I don't know." We saw monthly office meetings, registered care and care and well-being meetings were taking place. The manager said it was difficult to have full staff meetings but they communicated with staff at least weekly and staff were able to call into the office during the week.

We saw displayed in the office a 'you suggested, we did' poster. This included examples of feedback given and how the service had responded, such as 'I feel rushed within the 15-minute call and would like extra time to spend with clients', where the response was, 'going forward we have increased our minimum call time to 30 minutes'. We saw office staff meeting minutes from July 2018, which included discussion regarding MARs, client assessments, CQC inspection, communication, documentation and recruitment.

We spoke with the manager and chief executive about partnership working and they told us they worked with health and social care professionals to ensure people had the benefit of specialist advice and support. During the person's care assessment, the manager and chief executive told us people were made aware they could access a 'listening line', if they were experiencing loneliness, during the person's care assessment. It was explained what neighbourhood schemes the service was linked to and what the community centre could offer. The provider also worked in partnership with a befrienders group. This helped to provide effective outcomes for people they supported.

Notifications had been sent to CQC about events that had occurred at the service, as required by legislation.