A S Home Care Services Ltd

Home Instead Senior Care

Inspection report

Suite 6, The Parflo Building
Huxley Street, Broadheath
Altrincham
Cheshire
WA14 5EL

Tel: 01618701136
Website: www.homeinstead.co.uk

Date of inspection visit:
01 November 2018
06 November 2018
07 November 2018

Date of publication:
10 January 2019

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 between 01 and 07 November 2018 and was announced.

This service is a domiciliary care agency. It provided personal care to people living in their own houses and flats in the community. The service supported older adults who were living in the Trafford and Wythenshawe areas of Greater Manchester. At the time of our inspection, the service was providing support to 177 people, of whom, 71 received support with the regulated activity 'personal care'. All people using the service either fully or part funded their own care.

Not everyone using Home Instead Senior Care received a regulated activity; CQC only inspects the service being received by people provided with 'personal care', which includes help with tasks related to personal hygiene and eating. Where people receive such support, we also take into account any wider social care provided by the service.

We last inspected Home Instead Senior Care in January 2016 when we rated the service good overall and in all key questions other than well-led, which was rated outstanding. At this inspection we found the evidence continued to support the rating of good, and there was no evidence or information from our inspection and ongoing monitoring that demonstrated serious risks or concerns.

The registered manager had recently resigned, and finished working their notice during this inspection. We saw the provider had recruited a new manager who had accepted an offer of employment and was working their notice in their current post. 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 received a reliable service from staff who attended their calls in a timely manner. There had been no missed calls to people receiving a regulated service in the past year, and people told us staff turned up on time. The provider had systems in place to monitor staff availability when deciding whether they had capacity to accept new care packages.

Staff assessed risks to people's health, safety and wellbeing. Whilst some risk assessments were limited in detail, we found staff were aware of appropriate steps to take to keep people safe. Risks were also reduced as people received support from consistent staff teams.

Staff provided the support people needed to take their medicines as directed. However, in one case, we found staff had not followed safe procedures, and the provider's own policy in relation to the administration of over the counter medicines. We saw the provider was introducing a new medicines administration policy at the time of our inspection that staff were receiving training in. The director confirmed this covered requirements in relation to the administration of over the counter medicines.

People's needs were assessed prior to staff starting to provide a service. People felt that Home Instead Senior Care had a good understanding of their needs and preferences. People were supported to access other services to meet their health and social care support needs. However, we found some assessments were limited in detail and had not always been updated promptly following changes in people's needs.

Staff received support and an induction that prepared them to undertake their job roles. People told us they were confident that staff had the skills and experience needed to meet their needs. We saw the provider carried out staff spot-checks and competency assessments. Reviews of people's service also considered whether staff required any additional training to meet people's assessed needs.

People were asked to sign forms to different aspects of their planned care and handling of records and information. However, we found shortfalls in this process. For example, one person had signed a consent form when they did not have capacity to do so, and other people had not consented to aspects of care that staff were carrying out. It was not always clear how decisions in relation to people's capacity had been made, although we saw the provider had carried out adequate formal capacity assessments and best-interest decisions in relation to more significant decisions about people's care.

People received support from small, consistent teams of staff. The provider had a system whereby no person received support from a staff member until they had been formally introduced. This helped ensure staff were aware of people's needs and preferences and were able to build positive, trusting relationships with them.

Feedback from people using the service about their care staff was consistently positive. We received multiple comments from people who told us that their care staff were more like friends, although they stated they were also aware of professional boundaries. The provider had a policy of only carrying out calls of a minimum length of one-hour, which staff and people using the service felt helped people build relationships, and staff provide person-centred care.

The service produced a 'what's on where' guide that provided information about community events, groups, charities and support groups. The provider told us these were handed out to all people using the service and by other health and social care professionals. The provider was involved in arranging or supporting a number of initiatives that aimed to reduce the risk of older adults becoming socially isolated, and developing dementia friendly communities.

People and their representatives were involved in planning and reviewing their care. People told us staff understood their needs and preferences, and we saw care plans documented people's preferences and social histories. Where it was part of people's planned care, we saw staff supported people to take part in meaningful activities, and remain a part of their communities.

People told us they had not had cause to raise any complaints but said they would feel confident doing so if needed. We saw previous complaints had been investigated and responded to appropriately.

There was a significant management structure in place to support service delivery. This was in addition to support the service received from the franchises national office. The service had grown since our last inspection. Because of this, the director had introduced a new management structure, with separate teams that focussed on people using the service (the client experience team), staff (the care givers team) and a planning/development team.

There was a high level of satisfaction amongst people using the service who talked about receiving a reliable

and professional service. Staff were also motivated, and we saw the opinions of staff and people using the service were sought and considered as part of the service's drive for continuous improvement.

We found there was a system of checks and audits to help the provider/management team monitor the safety and quality of the service. However, these checks had not identified the issues we found in relation to medicines management, consent forms/capacity assessments and the review of care for people with deteriorating health.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service remains good.	Good
Is the service effective? The service remains good.	Good
Is the service caring? The service remains good.	Good
Is the service responsive? The service remains good.	Good
Is the service well-led? The service has deteriorated from outstanding to good.	Good

Home Instead Senior Care

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 was a comprehensive inspection that took place between 01 and 07 November 2018. The inspection was announced. We announced this inspection on 30 November 2018, which gave the provider approximately 40 hours' notice. This was so that the provider could help us arrange home visits to people using the service, and check whether people would be happy to receive a call from us to ask about their experiences using the service.

The inspection team consisted of an adult social care inspector, a bank inspector 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. On 01 November an expert-by-experience made calls to people using the service. We visited the service's office to review records and speak with staff on 06 and 07 November 2018. We also visited people using the service at home on 07 November 2018.

Prior to the inspection we reviewed information we held about the service. This included previous inspection reports and statutory notifications the service had sent us. Statutory notifications are information services such as Home Instead Senior Care must send us about significant events such as safeguarding, deaths and serious injuries.

We used information the provider sent us in the Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We requested feedback about the service from Trafford Local Authority's quality and commissioning team, and Trafford Healthwatch. Neither party had any relevant information to share about the service. We received responses from questionnaires completed by 20 people who used the service or their friends/relatives and 16 staff members. We considered the responses from people's questionnaires as part of the inspection planning process.

During the inspection we spoke with 14 people using the service or their relatives by telephone. In addition, we visited four people at home where we spoke with them, their relatives (when present) and four members of care staff. We spoke with a further 11 staff at the office. This included the director, five care staff/senior carers, the scheduler, head of client experience team, a team leader and the lead trainer.

We looked at records relating to the care people were receiving. This included nine care files, daily records of care and six people's medicines administration records (MARs). We looked at other records relevant to the running of a domiciliary care service, including; six staff member's personnel files, records of training and supervision, policies and procedures, audits and quality assurance checks and records of accidents/incidents.

Good

Is the service safe?

Our findings

At our last inspection in January 2016, we rated this key question as good. The rating remains good.

The provider employed sufficient numbers of staff to ensure they could attend people's planned calls. The provider had systems in place that enabled them to plan how many staff they needed. They employed a professional 'resource planning manager' who had devised procedures for monitoring the times of the day when staff were available.

People told us that staff were reliable, arrived on time and stayed for the agreed call duration. One person told us, "The girls come when they should, I can rely on them" and another person said, "I feel safe because they don't miss any calls and are on time". Information from the provider's electronic call monitoring supported the finding that staff attended calls in a timely way. This system also provided alerts to office or on-call staff if care staff had not attended a call within a 20-minute tolerance. This enabled office based staff to check were care staff were and to provide cover if required. The director told us there had been no missed calls to people receiving a regulated service in the past year.

There were robust procedures in place to help ensure staff employed were of suitable character to work with potentially vulnerable people. We saw all staff had professional and character references on record, along with other required checks and documents. This included proof of identity, a health declaration, recent photo and a disclosure and barring service (DBS) check. A DBS check provides details of any convictions, and, dependent on the level of check, a record of whether the applicant is barred from working with vulnerable persons.

Providers are required to obtain a full employment history for staff they employ. Whilst this was in place for most staff members, one staff member had gaps in their employment history without a recorded explanation. There was a note that this person's interview records that their employment history had been discussed, but the provider had not kept a record of the given reasons. We saw the provider had followed disciplinary procedures when they had become aware of concerns relating to staff members' conduct or practice. This including carrying out investigations and issuing warnings.

Staff kept records of medicines they administered to people. We saw people's care plans detailed the support people needed from staff to manage and take their medicines. We saw that in most instances, staff had identified and appropriately followed-up any potential or actual medicines errors. However, in one instance we found staff had not followed the provider's policy in relation to the administration of over the counter medicines (homely remedies). Staff had recorded that they had administered such medicines at the request of the person using the service. However, they had not sought advice from the person's GP or a pharmacist before doing this, as the provider's medicines policy instructed. Whilst there was no evidence that this person had sustained any harm because of this, it is important that advice is sought from a relevant professional before administering over the counter medicines. This is to ensure they do not have any potentially adverse interactions with other medicines that person is taking. In another case, staff had not updated a person's care plan and consent records to reflect that staff were helping them with their

medicines for a brief period.

During the inspection we saw that staff were receiving training in a new medicines policy that the franchiser (Home Instead Senior Care) had introduced. The director told us the policy had been updated to reflect best practice guidance recently issued by NICE (the National Institute for Health and Care Excellence). They also confirmed that the training covered the requirements in relation to administration of over the counter medicines, and told us any failure of staff to follow the policy would be reported as a medicines error, and staff would be given additional supervision.

We saw that staff completed audits of medicines administration records (MARs), and where potential medicines errors were identified, these had been appropriately followed-up. This had included re-assessing staff competence to administer medicines where medicines errors indicated potential concerns in relation to their practice.

Staff had assessed potential hazards that might affect people's health, safety and wellbeing. For example, we saw risks relating to falls, behaviour that challenges, eating and drinking and skin condition had been assessed. Care plans outlined the ways in which staff should help reduce identified risks, such as reducing falls risk by ensuring people's mobility aids were close by, and ensuring they wore a falls pendant if they had one.

Some people's risk assessments would have benefitted from additional detail. For example, one person's care plan directed staff to cut up their food into 'small' pieces, without the specific size being stated. Another person's care plan did not detail how staff should support that person with a piece of moving and handling equipment. However, staff we spoke with were aware of the identified risks and the risk management procedures in place for the people they supported. The provider operated a system whereby people were only supported by a staff member who had been previously introduced to them and had 'shadowed' a call with a staff member who knew that person. This reduced the potential for staff not being aware of how to provide people with safe care that met their needs.

The service had a basic contingency plan in place. This provided advice to staff about the actions they should take in the case of unforeseen events such as severe adverse weather or loss of access to office premises and files. Staff risk assessed the safety of people's home environments, and whether there were any potential hazards that might impact the safety of either staff or people using the service.

People told us staff left their homes tidy and cleaned up after themselves. During our visits to people's homes we saw staff carried personal protective equipment (PPE) such as gloves and aprons, and they were aware of good practice in relation to infection control. One person we spoke with told us, "They [staff] wear gloves and aprons which is hygienic. They tidy my house, which prevents me from having falls."

Staff completed accident forms if people sustained a fall or any injuries. Accident forms detailed any immediate actions staff had taken, such as contacting emergency services or first aid. They also recorded any follow-up actions required to help minimise the likelihood of a repeat incident.

We saw the former registered manager had completed a monthly summary of accidents that had occurred, noting if they identified any trends. However, this had not been completed since July 2018. The director told us, and we saw that there had been few incidents and as such, no patterns identified. They told us in the future staff would record such observations on the relevant log. We noted that there was no single overview of accidents sustained by individuals in either the accident file or their care files. The director assured us that repeat accidents would be picked up through the individual reviews of people's care staff carried out. This

was supported by our finding that staff had updated people's care plans following incidents such as falls to reflect this, along with details about how the service was managing these risks.

Statutory notifications sent to the CQC about safeguarding incidents demonstrated that the service was identify and appropriately escalating such concerns. This included making referrals to the local safeguarding authority and police as necessary. Staff were aware of signs to be aware of that might indicate people were at risk of abuse or neglect. They told us they would report any such concerns to a manager immediately.

Good

Is the service effective?

Our findings

At our last inspection in January 2016, we rated this key question as good. The rating remains good.

Senior carers carried out assessments of people's needs when they first started using the service. We spoke with a senior carer who said they were able to shadow a more experienced colleague before carrying out assessments alone, and they told us they were always able to seek advice and support from other members of the team if the assessment was more complex. One relative told us "I initially called another agency, but felt they didn't listen to what I wanted. As soon as I called Home Instead, they understood what I wanted."

Assessments covered a range of potential support needs, including those relating to people's health, communication, medicines, mobility, continence, conditions such as dementia and social/emotional support needs. We found staff had completed assessments to variable levels of detail. Some assessments clearly identified the objectives of the support provided and what staff needed to do to meet people's assessed needs. Oher assessments were more limited and did not always reflect the support that people needed or were receiving.

Records showed the service worked in conjunction with people's families/representatives and a range of health professionals, including district nurses and GP's to meet people's health needs. Relatives and people using the service told us they were confident that staff closely monitored their health and supported them as required to meet any health care needs.

Despite these positive findings, in one case, a person's daily records indicated that there were signs their health was deteriorating. It was not clear from the records how staff had initially escalated concerns about this person's health, and where responsibilities lay between Home Instead Senior Care, and this person's family in relation to arranging for other professionals to be involved. Following an initial delay, staff did carry out a review of this person's care and they were in the process of updating their assessments to reflect their changing care needs. Following this review, staff had worked pro-actively with other health care professionals to ensure this person's needs were met.

Where staff provided support to people with meal preparation and/or eating and drinking we saw their care plans recorded details about their dietary requirements and preferences. One person's care plan we looked at contained particularly detailed advice for care staff in relation to how to prepare and present a person's food to meet their needs and preferences. This would help staff provide consistent and person-centred care to this person. A second person's care plan recorded details about their food preferences as well as how staff could support them to be involved in aspects of food preparation.

Staff told us they would always leave food and drinks in reach of people they visited in accordance with their care plans. One person told us, "They [staff] check whether I have enough to eat and drink, and they document this fact." We saw the provider had produced a magazine for distribution in the local community that provided advice on staying 'safe and healthy at home'. This included prompts about ensuring people drank enough during the day, and advised that Home Instead could assist by supporting people to produce

weekly meal planners, or tracking nutritional intake. We saw an example template for the meal planners that staff could support people to complete.

People were confident that the staff supporting them had the skills required to meet their needs. One person told us, "I can't speak highly enough about them [staff]" and another person told us that without the care staff's knowledge of their family member's condition, they would not have been able to continue living independently in their own home.

Staff felt they received sufficient training to give them confidence in their abilities to meet people's needs. We saw a range of training relevant to people's job roles was carried out that covered topics including, safeguarding, end of life care, health and safety, dementia, food safety, moving and handling and basic life support. Staff told us if they were interested in a particular course, they could put their name down and would be informed when space was available for them to attend.

In most instances, new staff completed three days of training prior to starting to shadow more experienced staff and be introduced to people they would be providing support two. We were told that more recently, some staff did the induction training over two days with follow-up 'homework'. The provider told us the induction was based on the care certificate standards. All new staff were supported to complete the care certificate, which the training manager monitored. The care certificate outlines standards that all staff new to health and social care are expected to meet as part of their induction. It helps ensure they have the required skills, knowledge and behaviours to provide safe and effective care. Staff told us they felt confident their induction adequately prepared them for the work they did. One member of care staff told us, "[The induction training] was very thorough. [Staff member] who gave the training gave us their number so we could ring for advice about the training at any time. After the training I did shadowing with staff, then for my first calls I was not given people with challenging needs."

Records showed there were regular catch-ups or 'mentoring sessions' with staff during their 10-week induction period to check how they were getting on. Additional support was provided to help ensure new staff were competent and confident where a need was identified through this mentoring process.

The provider operated a system of spot-checks, support visits, supervisions and an annual appraisal to help ensure staff were competent and received the support they needed. Spot-checks included observations of staff practice and interactions with the person they were supporting. Care staff received feedback from these observations that would help them improve their performance, as well as highlighting areas where they were already demonstrating good practice.

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.

The provider needed to strengthen their practice in relation to working within the MCA. Where people had capacity to consent to their care we saw they had been asked to complete consent forms. One senior carer we spoke with told us they would leave consent forms with people and collect them at a later time to allow them chance to look over and consider their responses. However, two people had not ticked to indicate they had given consent to specific areas of care, including medicines administration for one person, and keeping daily records of care for another person. In both instances, these tasks were, or had previously been

undertaken by staff. A third person had signed their consent form when staff told us they would not have had capacity to do so. Despite finding issues in relation to documentation, we did not have reason to suspect staff were not working within the principles of the MCA in their day to day practice. This was based on our positive findings about the caring approach of staff, and feedback from people using the service.

Whilst the provider was able to evidence they had previously completed appropriate capacity assessments and best-interests decisions, two people's care records referred to them having 'confusion' and 'dementia', but there was no apparent further consideration in relation to their ability to make decisions about their care. People's care plans contained a section that referred to their abilities and support needs in relation to 'decision making'. Although this was good practice, a third person's care plan stated they had been 'deemed to lack capacity' and stated all decisions should be made by a family member. There was no evidence on file that this person's family member had legal authority to take decisions on their family member's behalf, although the provider told us this was later obtained. It was also unclear about who had made the decision that this person lacked capacity, how they had made this decision, or what decisions this related to.

We saw the provider's policy in relation to the MCA and carrying out capacity assessments had been recently revised. There was also guidance in the form of a 'flow-chart' that staff could refer to, to help them decide whether they needed to carry out a capacity assessment or best-interest decision. One of the team leaders we spoke with told us they had recently attended training around the MCA. They told us this had helped them better understand about requirements relating to the assessment of capacity, and evidence required in relation to people who had relatives or others with a lasting power of attorney (LPA). A LPA can give a person legal authority to take particular decisions about another person's financial affairs and/or care and welfare.

Good

Is the service caring?

Our findings

At our last inspection in January 2016, we rated this key question good. The rating remains good.

Feedback from people using the service and their representatives was consistently positive about the caring and professional nature of staff. The expert-by-experience on the inspection team reported, "I would certainly recommend this service to my own [family member] based on the consistent evidence that I was given. In terms of the family and friends test, I would certainly give it outstanding."

People received support from small, consistent teams of staff, which helped staff and people using the service get to know one another. The provider also attempted to match care staff (known as care givers) with people using the service based not just on availability, but people's preferences, shared interests and staff members' strengths. Comments from people using the service, our observations during home visits and conversations with staff suggested this process was generally successful, although rotas/scheduling and availability of staff could sometimes be a barrier. Comments we received included, "I can't speak highly enough about them [staff], they are like extended family", "[Staff] are very nice and I feel I can talk to them all. I've known them a long time now, they are more like friends, I can say how I want things" and "They [staff] are more like friends, but they know their boundaries."

The provider went to great lengths to ensure that people were only visited by staff whom had been formally introduced to that person previously. Records were kept evidencing the 'introductions' that had taken place. If their assigned member of care staff was off work, a 'switch around' system was implemented to free up another member of their regular staff team. As a last resort, 'responders' based at the office who also knew that person would be assigned to carry out the call. This helped ensure people received person-centred care from staff who knew them, their needs and preferences. One relative told us, "It's a true partnership between us. Because they [staff] are regular I don't have to keep explaining how I want things done." They also explained that they had asked that care staff acted in a 'bright and breezy' manner to help them engage effectively with their family member. They told us staff always adopted this approach as requested. We observed that staff took time to communicate effectively with this person's family member and maintain eye contact.

We asked staff what they felt Home Instead Senior Care did well. One staff member told us, "Building up small teams who work with people and focusing on all aspects of people's lives such as the social and physical aspects of care." A second staff member told us they had previously worked for a different home care agency whom they had a less positive view of. When asked what they thought the key differences were between this agency and Home Instead Senior Care, they told us they thought the minimum one-hour call duration, and the staff the provider recruited made a significant difference to the quality of care people received. They told us the staff member in charge of recruitment was 'excellent' and would not employ someone if they 'didn't have a feel for them'. We saw the provider had completed an exercise where they had considered the characteristics and experience they thought would make a good 'care giver' and that they wanted to attract in potential applicants. This included people who were 'mature, local, drivers, and who had personal experience of care' for example, although the provider told us they did employ people

who did not fit this description who they felt could still make a good member of care staff for people the service supported.

The provider had a policy of only delivering calls of a minimum duration of one hour. This had contributed to people building positive relationships with staff. It also enabled staff to provide care that not only met people's primary assessed needs, but also gave them time to interact with people socially. In many cases, staff also provided support to people to access their local community or take part in activities they enjoyed. This also had the benefit of helping reduce the risk of people becoming socially isolated. For instance, in one person's care plan we saw staff had developed a schedule of meaningful activities in the person's local community. It was recognised that this had benefits not only for the person, but also the wellbeing of their family carer.

The provider continued to produce 'what's on where' guides, and they had developed this to produce guides for smaller geographical areas and communities. The director told us the aim of these guides was to inform people of what was going on in their local communities, with the added benefit of people remaining active and involved in their communities and being at reduced risk of social isolation. They told us other branches of Home Instead Senior Care had been encouraged to produce these guides, and that they were popular with professionals such as social workers who would hand them out to people they were working with. These guides were handed to all people when they started to use the service, and also contained information and contact details for local charities and support groups.

The director spoke passionately about developing 'dementia friendly' communities. They told us they were encouraging the relative-carer of one person they worked with to write an article for a magazine they were producing to share their knowledge about local businesses such as hairdressers and shops that were accessible to and provided a good service to people living with dementia.

People told us staff supported them or their relative to retain their independence. One person we spoke with told us they felt 'empowered' by the care staff and said, "They assist me, and they do not take over". Staff understood the importance of supporting people's independence, and told us they would be guided by the person and their care plan as to what they were able to do themselves. One staff member we spoke with told us when they had started the role they had found themselves doing too much, but had found "… sometimes less is more. Encouragement and self-esteem is important, which can be helped by supporting people to do as much as they can themselves." Speaking about a person they provided support to, they told us they were very independent and said, "It's important to let [Person] have that control, we [staff] are the guides and let [Person] take the lead unless it's a real safeguarding issue."

People were happy that staff respected their privacy and treated them with dignity and respect. One example was that staff would always ring the door-bell or knock on a person's door before entering, even if they had access to a key to let themselves in. One person told us that staff always respected their wishes and would finish a call early for example, if requested to do so because the person had a visitor. People told us they were confident that staff and the service as a whole would handle their personal information with care and maintain confidentiality of information and records. We found the offices were tidy and well-organised with no paper based records being left out unsecured. We saw staff were asked to read and sign the provider's confidentiality policy when they first started working for the service.

The provider told us in their provider information return (PIR) that they supported people from a diverse community, which was supported by recent census data. They told us they employed staff from diverse backgrounds, and said that this had previously enabled them to match care staff with people who shared the same first languages for example. We saw little in the way of assessment that would help staff identify if

people had any support needs relating to protected characteristics. For example, there were no prompts in the care plan for staff to record details about people's race, religion or sexual orientation, and what this meant in relation to the care and support they received, if they wished to share this information. However, the evidence we reviewed indicated that where such support was required, staff met people's needs. For example, one relative told us staff helped their family member 'maintain their faith' by taking them to church.

Good

Is the service responsive?

Our findings

At our last inspection in January 2016, we rated this key question as good. The rating remains good.

People were involved in planning and reviewing their care. People, and when relevant, their families/representatives told us they had been involved in developing and reviewing their care plans. Staff carried out annual 'service reviews' and 'quality assurance' visits for each person where their care was reviewed and feedback sought from them about what was or was not working well. We saw family members and people using the service had signed these documents to indicate their involvement in the process, and agreement with what they recorded. We saw that these reviews led to staff revising people's care plans as needed based on the feedback they received.

Staff understood and worked to meet people's preferences in relation to how they received their care. Speaking with staff, it was apparent that they knew the people they supported well. This included details about their care needs, social histories and preferences. Consistency and staff knowledge about how to support people in a person-centred way was aided by the small consistent care teams, and the 'switch-around' procedures that ensured people were not supported by staff they did not know.

Care plans contained information on people's social histories, interests, hobbies, likes/dislikes and preferences in relation to how they received their care. This included overviews of the key tasks staff were required to carry out, as well as details about people's preferred routines when receiving care and support. In some cases, these routines were very detailed and specific to help enable staff to consistently provide care in the way that person preferred.

One person's care records we looked at recorded that they preferred not to receive support from male staff. However, we saw from the rotas that a male member of staff had regularly provided their care. Staff told us that this arrangement had been discussed and agreed with this person, and that they were happy with the staff currently providing their support. However, this had not been clearly documented within their care records. We spoke with the relative of another person using the service who told us they had specifically requested support from male care staff. They told us they were happy that this preference had been met as their family member now had three male care staff as part of their care team.

Care plans recorded any support needs people had in relation to how staff provided them with information and communicated with them. For example, care plans noted whether people needed to use glasses for reading or hearing aids. Care staff were directed to use a white-board to communicate with one person because of a hearing impairment. We saw the staff manual also made staff aware that documents/information could be provided in alternative formats including Makaton and brail if required.

None of the people we spoke with told us they had felt the need to raise a formal complaint, though all told us they would feel comfortable doing so if they had any concerns. People told us they were confident they could express their opinions about the service, and that they would be taken into account in a constructive and positive way. One person told us, "I've never had any concerns or problems. I wouldn't use them [Home

Instead Senior Care] if I did" and another person said, "If I didn't like any of them [staff] I'd get rid of them. I'd phone my son and he'd get onto [Director] about it." We saw that the provider had appropriately investigated and responded to formal complaints they had received. This included issuing an apology when required and taking actions to address any concerns people had raised. One person who had raised a formal complaint had responded to the provider's outcome letter and had stated that they were satisfied with the provider's investigation and the outcome of their complaint.

The provider had recently introduced new end of life care training that several staff we spoke with told us they had recently completed, or were due to complete. The director told us no-one using the service was receiving end of life care at the time of our inspection. We did not see details recorded in people's care plans about end of life care wishes, although one relative we spoke with told us staff had discussed this with them. Another person using the service told us they had a DNACPR (do not attempt cardiopulmonary resuscitation) order in place that they kept at home. We saw there was reference to this within this person's care records, and a copy was also kept in the office copy of the care file. This would help ensure staff were aware this was in place should this person be in a situation where they required emergency care.

People were supported to take part in meaningful activities and remain a part of their communities. Staff had assessed and recorded people's social support needs, along with any risk of that person becoming socially isolated. Many people supported by Home Instead Senior Care received 'companionship support' and support to take part in activities they enjoyed in addition to the support they received with personal care, eating and drinking and medicines for example. This included staff supporting people to access local facilities such as local shops, or to go to the pub or community groups. One relative we spoke with told us staff supported their family member maintain an interest in past hobbies, by for example, discussing them with that person, looking at old photograph albums and supporting them to attend their church. Another person told us staff completed cross-word puzzles with them.

Good

Is the service well-led?

Our findings

At our last inspection in January 2016 we rated this key question outstanding. Whilst the service continued to display some characteristics of outstanding, the rating of this key question has declined to good. This is because some of the shortfalls we found in relation to practice in relation to consent, monitoring changes in people's health and the safe administration of medicines had not been identified by the providers quality assurance processes.

There had been two changes in registered manager since our last inspection in January 2016. The most recent registered manager was registered with the CQC to manage the service in March 2018, and had given notice of their intention to leave the service prior to our inspection. They left the employment of Home Instead Senior Care on 02 November 2018. The director showed us evidence that they had recruited a new manager to the post. At the time of our inspection, they were working their notice period at their current job prior to starting with Home Instead Senior Care. The director had carried out an analysis of the tasks usually completed by the registered manager so that other managers within the service could cover these responsibilities in the interim.

'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.'

There was an extensive management structure in place to support the effective running of the service. Since our last inspection, the service had grown by approximately 36 percent in terms of the number of people who were provided with a service. Because of this growth, the director told us a new management structure had been put in place within the past year. The new structure consisted of three separate teams, each with their own manager, and with defined responsibilities relating to care staff (care giver team), people using the service (client experience team) and planning/development. Within the client team, there were client leads who were also supported by senior support workers. Staff we spoke with felt this management structure was working well. The director spoke about employing the right people to do the job. For example, they had employed a professional resource planning manager to help the service schedule calls and manage resources effectively.

The director had a clear sense of direction in relation to how they wanted to develop and improve the service. We saw evidence that staff had been involved in reviewing what each of the three teams did well, and how they could improve what they did. This linked with business planning and objectives that had been set for each team. The franchises national office provided support to the branch with various functions. This included provision of certain training courses and policies and procedures and general advice and guidance. We saw the franchiser made new policies available to the branch, along with briefings on any key changes and advice on how the branch rolled out the new policies. For example, we saw a new medicines policy was being introduced, and this involved a full briefing/training session for all care staff. This would help ensure staff were aware of and followed the policy to deliver safe and consistent support in relation to

medicines management.

This branch of Home Instead Senior Care is part of a larger national and international franchise. The director spoke about the benefits of 'local passionate owners, operating an internationally proven model'. The service operated within a relatively small geographical area, and the director talked about aiming to place local people (care givers) with local people (clients). The director and other staff based at the branch continued to organise community events and initiatives with the aim of preventing social isolation amongst older adults, and creating more dementia friendly communities. For example, staff arranged a 'Santa to a Senior' project, which encouraged people to make Christmas cards and donate gifts that were then distributed to older adults in the local area. The director told us staff had also worked with local schools and other groups to make cards for people, and spoke about this having the benefit of making children more aware of who lived in their communities, and that not all people living on their street would have the same family support that other older adults had. Staff from the service had delivered 'dementia friends' training to local church groups, and the director spoke enthusiastically about work they currently undertook, or were in the process of developing to help build more dementia friendly communities.

All people we spoke with expressed a high level of satisfaction about the service they received. They told us they thought the service was well-led, and told us they were always able to get in touch with someone should they need to discuss any aspect of their service. People spoke about receiving a professional service from a well-led organisation. We saw the service had received compliments and letters of thanks expressing similarly positive sentiments, such as 'Thank-you for your hard work and support' and 'Thank-you for the dedicated and professional care.'

We saw the service sought regular feedback from people using the service through a variety of tools, including feedback at people's individual service reviews and quality assurance visits, and though an annual survey. This survey was carried out by an independent company and enabled the service to monitor its' performance against previous years and other Home Instead branches. The director had set targets to improve the scores they received in this survey, which in most instances the branch had achieved. We saw the outcome of the most recent survey was an agenda item for the 'client experience' team meeting.

Staff we spoke with were motivated, felt well supported and told us they thought the service was well-led. A survey of staff opinions about the service was undertaken alongside the client survey, and target scores were also set for the outcomes of this survey, with the aim of continuously driving improvements. The last survey completed showed that 100 percent of the 70 staff who completed the survey had indicated they were clear about the service's goals, and were satisfied with the training and support they received. We saw a staff newsletter was produced that kept staff informed about developments in the service along with general useful information and advice. We saw the service was undertaking work to help maximise staff retention, which would have resulting positive effects on the consistency of care people received. However, care staff were employed on zero hours contracts, which meant they were not guaranteed a minimum number of hours work. Due to the positive system of staff working in dedicated teams, this meant the hours staff worked could be reduced at short notice. Some staff and people using the service felt this contributed to a higher level of staff turnover than they would otherwise have expected.

We saw the franchiser had completed a comprehensive audit of the service in August 2018. This considered aspects of service delivery including training, care plans, introductions, technology, registration requirements, staffing and branding. This helped the manager/director monitor the branches performance and compliance against both regulatory requirements, and the requirements of the franchiser. We saw that an action plan had been produced from this audit that staff had updated as actions had been completed.

There were systems in place to help the director/managerial staff monitor the quality and safety of the service. For example, we saw the timeliness of calls was monitored using electronic call monitoring software. This system required staff to 'log-in' when they started calls using the person's telephone. The director said this system was currently under review as they did not feel comfortable with the need for this to be the first thing staff did when arriving at a person's home. We saw call monitoring data was reviewed to check that calls were carried out in a timely way, and staff supervisors reviewed this information with individual staff members to help identify any performance issues. There were systems to monitor when training, supervisions, spot-checks, quality assurance visits and reviews were due. Where the system had flagged that these were overdue, the relevant manager had identified actions that staff needed to take or they had provided an explanation as to why there was a delay in completion.

People had an annual service review and quality assurance visit. We saw staff reviewed the care people received during these visits, and the reviewer was prompted to considered whether staff may require any additional specific training to enable them to meet people's needs effectively. Checks of relevant documentation such as risk assessments, care plans and medicines records were also completed. We saw daily records of care and medication administration records (MARs) were returned to the office regularly, where senior carers would review them and take action based on any identified shortfalls or indicated changes in people's needs.

Despite these systems, some of the shortfalls we found during this inspection had not been identified, nor acted upon in a timely way. For example, staff had not identified the issues we found in relation to the administration of over the counter medicines reported on in the safe section of this report prior to us raising this issue. Issues in relation to the completion of consent documents had also not been previously identified by staff, and changes in people's needs had not always been reflected in care plans in a timely way.

Staff told us they felt the service had an open and honest culture. When asked if they would feel confident that they would be treated fairly if they had made a genuine mistake. Staff replies included, "Yes, I'd be confident to be open about any mistakes" and "Yes, it's always better to ring and say something. I would feel supported, rather than judged." We saw staff were asked to read and sign the whistleblowing policy when they started work, which would help ensure staff were aware of how they could raise and escalate any concerns they might have. The director told us that the office area for the 'caregiver team' had been purposely designed to be in a separate room to enable staff to feel confident to have confidential or sensitive conversations with their supervisor.

The provider was meeting the requirement to submit statutory notifications in relation to specified events such as safeguarding incidents that occurred during the delivery of a regulated activity. We saw the rating from the services' last CQC inspection was prominently displayed in the office as required.