Flexicare Altruistic Solutions Limited

Flexicare at Home

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place on 18 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location office when we visited.

Flexicare at Home is a domiciliary care agency that provides support to people who live in their own home, both older people and some younger adults with disabilities. They provide a service in the West Yorkshire area to people who have a service commissioned via the local authority and to people who are privately funded. The office is situated at Calder Park in Wakefield. At the time of our inspection 66 people were receiving support from the service, including two people who received live in care.

The service is required to have a registered manager, and at the time of our inspection there was a registered manager in 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.

We found that people's needs were assessed and risk assessments were in place to reduce risks and prevent avoidable harm. These were regularly reviewed to ensure they were reflective of people's current needs.

The provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. Staff understood the different types of abuse that could occur and were able to explain what they would do if they had any concerns.

The provider had a safe system for the recruitment of staff and took appropriate steps to ensure the suitability of workers. People that we spoke with told us that staff usually arrived on time and there was a system in place to ensure cover in the event of staff sickness or absence.

There were systems in place to ensure people received their medication safely. Where staff supported people with their medicines, this was accurately recorded on medication administration records. Staff had received training in administering medication and the registered provider regularly observed staff competency in this area.

Staff completed an excellent range of training, which enabled them to provide a highly effective service. Training was refreshed annually. Additional specialist training was provided in relation to people's individual needs where this was required, such as catheter care. Staff received regular supervision and support and were very regularly observed delivering care, to check their competence.

People were well supported with their nutritional needs and food preparation, where this was part of their care plan. People told us they were very satisfied with the support provided in this area. Staff were highly

skilled and proactive in encouraging those who had difficulty with eating, and we found examples of where this had led to significant improvements in people's well-being.

People were supported to maintain good health and access healthcare services. We saw evidence in care files of contact with other healthcare services, such as district nurses and GPs.

Staff had completed training on the Mental Capacity Act (2005) and were able to demonstrate an understanding of the importance of gaining consent before providing care to someone.

People told us that the staff who supported them were caring. People received support from a small team of people who they knew and with whom they had good relationships. People told us they felt in control of decisions about their care and also reported that their privacy and dignity were respected. Staff demonstrated a caring and empathic approach towards the people they supported, and we saw examples where staff went beyond the core tasks in the care package, where they felt the person may enjoy or benefit from something. Comments from people suggested this made them feel valued.

Everybody who used the service had a comprehensive care plan, which contained information about their needs, preferences and routines. Staff demonstrated an understanding of people's individual needs and people's comments showed us that staff were flexible and responsive.

There was a complaints, suggestions and compliments procedure in place and people who used the service told us they knew how they could raise a complaint if they needed to, and that they would feel comfortable doing this. The registered provider sought people's views about the service during regular review meetings.

There was a quality assurance system in place, which included regular observations of staff practice, care reviews and monitoring of care documentation. This enabled the registered manager to identify issues and measure the delivery of care. People we spoke with expressed a high level of satisfaction about the service 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.

There were systems in place to protect people from avoidable harm. The registered provider assessed risk in relation to people's needs. Staff had been trained in safeguarding vulnerable adults and knew how to report any concerns.

Robust recruitment processes and appropriate checks were completed before staff started work.

There were systems in place to ensure that people received their medicines safely.

Is the service effective?

Outstanding

The service was very effective.

Staff received an excellent range of training which was tailored to people's individual needs. Staff had regular supervision and competency observations.

People were well supported with their nutritional needs and food preparation where this was required. Staff were highly skilled and proactive in encouraging those who had difficulty with eating, and we found examples where this had led to significant improvements in people's well-being. People were also supported to access healthcare services in order to maintain good health.

Staff were able to demonstrate an understanding of the importance of gaining consent before providing care to someone.

Is the service caring?

Good

The service was caring.

People felt in control of the care they received, and told us that staff respected their privacy and dignity.

People told us that staff were kind and that they had a regular

team of care staff, with whom they had positive caring relationships.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed and care plans were in place to enable staff to provide personalised care. People told us staff were flexible and attentive to their needs.

Staff supported people to access social activities and community facilities where they wished.

There were systems in place to manage and respond to complaints and concerns.

Is the service well-led?

Good

The service was well-led.

Care staff were positive about the culture of the organisation and the support they received from the management team.

There was a quality assurance system in place to enable the registered provider to monitor the quality of the care provided. People we spoke with told us they were very happy with the care they received.

Flexicare at Home

Detailed findings

Background to this inspection

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

This inspection took place on 18 October 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in the location offices when we visited.

The inspection team consisted of one adult social care inspector and one expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our visit we looked at information we held about the service, which included notifications sent to us. Notifications are when registered providers send us information about certain changes, events or incidents that occur. We also contacted Wakefield Council's commissioning team to request feedback about the provider.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make.

As part of this inspection we spoke with seven people who used the service over the telephone and four relatives of people who used the service. We tried to contact a further eight people, but they were unavailable to speak with us. We spoke with a social care professional who worked for Kirklees Council. We also spoke with the registered manager, a care manager, a human resources manager, a human resources administrator and five care workers. We visited the agency office and looked at five people's care records, three care worker recruitment and training files and a selection of records used to monitor the quality of the service. Following our office visit we conducted a home visit to a person who used the service, in order to speak to them about their experience of the service and see the documentation held in people's homes.

Good

Is the service safe?

Our findings

We asked people who used the service if they felt safe with the staff and the support provided by the service. People told us they did, and their comments included, "Yes [I feel safe]. I know they wouldn't hurt me in any way and they take good care of me. I leave money around and I know they wouldn't touch it" and "I do [feel safe] because they're so caring. They know I'm disabled and get me out of bed in a certain manner, but they're always so gentle. I trust them." Others told us they felt safe because, "They're very attentive and very aware of where I am and what I'm doing" and "They [staff] are very gentle."

The registered provider had policies and procedures in place to guide staff in safeguarding vulnerable adults from abuse. All staff received training in safeguarding vulnerable adults as part of their induction training, then refresher training thereafter. Staff demonstrated a good understanding of how to safeguard people who used the service; they understood the different types of abuse that could occur and were able explain what they would do if they had any concerns. Staff told us they would report anything straight away to their manager. The safeguarding records we looked at showed that two safeguarding referrals had been made to the local authority in the last year and the registered provider had taken appropriate action to investigate and respond to these concerns. The registered provider also had a whistleblowing policy, which enabled staff to raise concerns. This showed that the registered provider had a system in place to manage safeguarding concerns and protect people from avoidable harm and abuse.

The registered provider assessed risk in relation to people's needs. They completed a general risk assessment for each person, which included environmental risks in the home, medical history, mental capacity and advocacy involvement, psychological risks (such as isolation) and financial risks. The registered provider also completed specific detailed risk assessments in relation to people's individual needs, where these were required, such as moving and positioning assessments and risk management plans for challenging behaviour. Risk assessments were regularly reviewed, every three months or sooner where needs changed in the meantime. We found one moving and handling assessment which had not been fully completed and the registered provider took immediate action to address this on the day of our inspection. All other risk assessments we viewed had been appropriately completed and were up to date. Staff were knowledgeable about safe systems of work and individual risks in relation to people they supported.

We saw that an accident and incident form was held in the care file in each person's home, so that staff had access to the necessary documentation to promptly record and report any incidents. Completed forms were returned to the office so that the registered manager could review the information. Accidents and incidents were also logged on the registered provider's computer system, with a record of any responsive action taken. The registered provider was able to track any outstanding concerns or required actions on their computer system. These records showed that appropriate responsive action had been taken following incidents, in order to prevent the risk of recurrence and address any concerns about people's health or care needs.

The registered provider had a 24 hour helpline which people could use if they had any concerns or needed assistance urgently. The registered manager told us that where appropriate, emergency services were

notified and a care manager visited immediately if a relative was unable to attend. They also supported people to go to hospital if required, and stayed with them until they were either admitted or discharged. We saw they had supported people to attend hospital on ten occasions in the year prior to our inspection.

The registered provider had a business continuity plan. This detailed how the provider would respond, and minimise the impact to people who used the service, in the event of an emergency such as adverse weather, office fire or the loss of electricity and telephone supplies.

The registered provider had a safe system for the recruitment of staff. We saw that appropriate checks were completed before staff started work. These checks included seeking appropriate references and identification checks. The registered provider also completed Disclosure and Barring Service (DBS) checks. DBS checks return information from the police national database about any convictions, cautions, warnings or reprimands. DBS checks help employers make safe recruitment decisions and prevent unsuitable people from working with vulnerable groups. The recruitment records showed us that the registered provider was taking appropriate steps to ensure the suitability of workers.

We talked to the registered manager, care staff and people who used the service about whether there were sufficient staff available to meet people's needs. The registered provider completed an initial assessment of people's needs, prior to providing support to them, and this enabled them to determine with the person the frequency, duration and preferred time of care visits. Staff rotas were then planned around these care visits, using the registered provider's computer system to ensure that call visits were matched to staff who worked with that person regularly. Where there was any sickness or unplanned absences other care staff who were familiar to that person were asked to stand in. Ten office based staff were trained to each cover care visits for a small set of people who used the service. This ensured the office staff knew the person's needs and routines. Office based staff also provided urgent, non-planned support to people in emergencies. The registered provider also had an on-going recruitment drive in order to recruit additional staff.

People we spoke with told us that staff were almost always on time, or within the fifteen minute timeframe allowed for the start of the call visit. One person told us they once had to ring the office because their care staff hadn't arrived, but everyone else we spoke with said someone from the office would ring them if ever staff were running late. People also told us that staff stayed the right length of time. Their comments included, "If they finish early they sit and talk to me," "They do all sorts of little jobs for me like taking the bin out and doing the ironing; they're very good" and "If there isn't anything left to do, they come and talk to me, which is nice."

This showed us that the registered provider had a system in place for ensuring there were sufficient numbers of staff to fulfil the planned care visits and meet people's needs.

The registered provider had a medication policy in place, which was available to all staff. Staff had received training in medication management and their competency was assessed before supporting people with their medication, and regularly thereafter. Care coordinators checked medication administration records (MARs) when they were returned to the office, to identify any gaps or issues. Any identified issues were then reported to a care manager to investigate and address.

People's individual care files contained details of their medication and any support required with this. We looked at a selection of medication administration records. We found one example where two duplicate handwritten medication records had been created, because staff had run out of printed copies and failed to report this to the office in time for them to supply new ones. This increased the potential risk of confusion or a medication error. However, the records enabled us to see that the person had received their medication as

prescribed and all the other medication administration records we viewed were appropriately completed. The care manager agreed to issue a reminder to staff about this, to prevent recurrence. People we spoke with who required support with their medication confirmed to us that staff always gave them the correct medication and on time. One person told us, "They know what they are doing with my medication. They always remember to give me it and they sort it all out for me."

This showed us that there were systems in place to ensure people received their medication safely.

Outstanding ☆

Is the service effective?

Our findings

We asked people who used the service if staff had the right skills and experience to do the job; people we spoke with told us they did. Their responses included, "Yes, and if they haven't, I train them!" "Yes they do" and "They know what to do when they come; they've been trained by Flexicare."

We saw that all staff received an employee handbook and completed an induction when they started in post. Staff also completed the Care Certificate. The Care Certificate is a set of standards that social care and health workers work to. It is the minimum standards that should be covered as part of induction training of new care workers. Staff confirmed to us that they shadowed other staff when they were new in post until they got to know people and were assessed as competent to work independently.

There was a strong emphasis on developing staff skills and potential, in order to deliver a highly effective service. The registered provider employed a training manager and there was a well-equipped training room at the office base. This training room contained a bed, various hoists and manual handling equipment, life size anatomical models and training tools which were used to practice manual handling and personal care practice. Training considered as essential by the registered provider for all staff included first aid, dementia, infection control and prevention, food safety, medication, moving and positioning, safeguarding, health and safety and nutrition and hydration.

Additional training was also provided by working in partnership with relevant healthcare professionals where this was relevant to the needs of people that staff supported, such as epilepsy, catheter care and stoma training. Where a person had a specialised care need, such as catheter care, oxygen home management or stoma care, a 'specialist care sign off form' was documented, and each member of care staff was individually supported through the risk assessed technique. The sign off form was signed by the care staff to state they felt confident with the technique and by the care manager to state the carer was competent in the technique.

There were distance learning courses on a variety of topics, such as diabetes, mental health awareness, common health conditions and end of life care. Many staff had also completed an intensive training course on the psychology of care, which was an innovative course developed by the registered provider. The majority of training was delivered face to face; certain courses delivered by external accredited trainers and others by suitably experienced staff from Flexicare at Home. Dementia training was provided by a registered nurse, trained in a nationally recognised dementia care approach.

The registered provider required staff to refresh their training regularly, in order to keep their knowledge up to date. The registered provider was able to monitor when staff were due to complete refresher training, as records were held electronically, and they regularly ran reports to identify any training due. Training records showed that the majority of staff were up to date with all their routine refresher training. A moving and positioning course was booked to take place on the week of our inspection, which showed that action had already been taken to address the fact that a number of staff required refresher training in this area.

Staff spoke highly of the training provided, and comments included, "The training is immense. It's fabulous" and "I enjoy the training. I have regular refresher training, such as moving and handling every twelve months. It covers everything I need to do my job and I could ask for extra training or support if I needed it." Another told us, "The training is 100%; I can't fault it." They went on to describe the psychology of care course they had completed and said, "I loved it…it was brilliant and well worth the 12 weeks [one day a week] it took to do."

We saw evidence of staff supervision and staff meetings; both covering a range of appropriate topics. Office staff had regular meetings, and care staff meetings were held whenever there was significant information or changes that needed to be shared on a group basis. In the meantime, staff were kept up to date with day to day communications from the office. Observations of staff practice were completed at least monthly, in order to monitor care delivery. This showed us that the registered provider was very proactive in monitoring staff effectiveness and that people received care from staff that had the knowledge and support they needed to carry out their roles.

We looked at the support people received with their nutritional needs. Some people who used the service did not require support in this area, because they were able to prepare their own meals and drinks independently. However, other people we spoke with received regular support from the service with their meals. Care plans contained information about people's nutrition and hydration needs, and the specific support and tasks required of staff were included in a service delivery plan. We saw that food and fluid intake records were appropriately completed, where these were required. Staff were knowledgeable about food preparation and hygiene practice, including support to ensure people's food stocks were in date.

The registered manager told us they provided samples of different foods and drinks to people where there were nutritional concerns, and that through monitoring, experimentation and nutritional variety people were encouraged to eat and drink well. We found this had resulted in people putting on weight. For instance, a community professional provided us with an example of one person Flexicare at Home had "Worked extremely well with." We were told the person had been very difficult to motivate to eat and had been frail and underweight. Prior to Flexicare being commissioned to manage all the person's shopping and meals, staff had used their initiative and started encouraging the person to eat more by bringing in samples of food, such as croissants and muffins, when they were calling to provide other care. This built up gradually over time until the registered provider was asked to provide full support with shopping and all meals. Staff used techniques like eating with the person to prompt them to eat, and encouraging them to be involved in cooking food from their country of origin. This was successful in helping the person to regain some interest in food. The community professional told us they believed the reason for Flexicare at Home's successful approach with this person was due to their determination and perseverance, along with finding the right staff to work with them; staff who had the tone and quiet manner the person responded to. They told us, "[Name] has put on some weight, albeit only a little bit, but it is noticeable and they just look so much better. Their whole well-being is better. The girls that go in are fabulous with [Name] and they have really increased the range of things that they will eat."

One relative told us the "Care and dedication" staff had shown with their relative's nutritional needs had been "Absolutely brilliant." They said their relative had been very reluctant to eat due to their dementia related condition and Flexicare at Home had arranged for a dietician to see them. They tried a range of approaches, including different food supplements, and Flexicare at Home managed and monitored this. The relative told us the person had increased in weight by about one stone in a two month period, from having been under six stone. They told us, "I cannot thank them enough. They battled and persevered and looked after them, and they are now eating and drinking. It's given [my relative] a new lease of life. There are always regular carers and this makes such a difference as my [relative] has dementia."

This showed us the registered provider used creative methods and positive relationships to encourage people who had difficulty with eating and drinking, in order to improve their well-being.

Other people that received support with meals told us they were very satisfied with the support provided. Comments included, "They prepare food for me and do exactly what I ask for," "They do make me some nice meals" and "I do some of the preparation but they finish off things and serve it to me. They are very good." One relative we spoke with told us, "From what I've observed, there's some forward planning with the carers. They may ask [my relative] in the morning what they want for their lunch and then, if it's in the freezer, it can be defrosted."

We looked at the support people received to maintain good health and access healthcare services. Records showed there was contact with other healthcare services, such as district nurses and doctors. For instance, we saw that staff had contacted a district nurse for one person who had a small pressure sore on their spine, in order to seek guidance and order dressings. This also demonstrated staff's vigilance in monitoring people's skin integrity. Contact details of any healthcare professionals involved in the person's care were in their service delivery plan.

People we spoke with told us that staff would support them to access the GP or attend appointments if they needed it. People told us, "There was a time once, when I went into a faint and spilt my porridge over me and [the carer] rang an ambulance" and "Tomorrow I have an appointment at the hospital and the carers are coming in early to get me washed and dressed before the nurse arrives. They have taken me to see the doctor a few times." Another person told us, "If I have a medical appointment they travel with me…There was a time when I needed to go to hospital quite a lot and they would phone 111." Relatives also told us that care staff kept them informed of any health concerns and one commented, "If carers observe any skin marks or sores they will inform me and suggest [my relative] sees a doctor." This showed us that people were supported to maintain good health and access healthcare services where required.

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. Where people lack mental capacity to make 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 when this is in their best interests and legally authorised under the MCA. For people living in their own home, this would be authorised via an application to the Court of Protection.

We checked whether the registered provider was working within the principles of the MCA. We saw evidence that people had been involved in decisions about their care and had signed to consent to their care plan. Clear records were maintained where people had a legal representative who was able to make decisions on the person's behalf where required, such as a Lasting Power of Attorney for health and welfare (LPA). There was also relevant information available to staff where one person was deprived of their liberty in an order granted by the Court of Protection.

Staff had completed training on the MCA and were able to demonstrate an understanding of the importance of gaining consent before providing care to someone. One told us, "One of the basic principles [of the MCA] is to assume people have capacity unless they are assessed otherwise. If they don't have capacity they may have an advocate or Lasting Power of Attorney involved and you need to act in their best interests."

Good

Is the service caring?

Our findings

When we asked people who used the service if staff were caring in their manner and approach; the feedback we received was very positive. People's responses included, "Yes I do," "Exceptionally. They are all really lovely girls. They bring me bits of cake to see if I approve. I'm really well looked after," "I'm very happy with them" and "Very. They're very concerned. Things like light bulbs; they'll change those for me. I've never come across anybody who wouldn't do what I asked them to do. They're happy to go the extra mile." Another comments included, "They're just kind. They take an interest in everyday things and what is happening to me; they are very caring" and "There was one carer who thought I would benefit from a wheat pillow and brought it for me. I didn't ask for it; she did it off her own bat. You put it in the microwave and it's very nice." Another told us, "They are all lovely, I've no complaints whatsoever. We're like friends. They have time for you; we talk whilst they are doing their jobs… I've just had a birthday and they sent me cards and flowers. Last Christmas they all bought me a present." This person suggested this made them feel valued. Relatives we spoke with also told us that staff were kind and caring.

We observed interactions between a staff member and someone who used the service and saw that these interactions were warm and friendly and there was clearly a positive and mutually caring relationship. They discussed something of interest to the person; a magazine that the staff member had brought them earlier. Staff we spoke with demonstrated a caring and empathic approach towards the people they supported and we saw examples where staff were going beyond the expectations of the person's care package, in order to care for that person. For instance, at the time of our inspection, the registered manager and staff were looking after the dog of someone who was temporarily in hospital. People generally had a core team of approximately four or five carers, and the registered provider ensured that in the absence of these regular staff at short notice, such as sickness or annual leave, cover was provided by other staff that had met the person and were aware of their needs.

People had choice and control about their care and felt their views were acted on. One person told us, "They always ask if there's anything else you want doing before they leave. They would always listen to me; we work together. It's more like a friendship." Another told us, "I definitely have control." People also told us that on occasions in the past where they had not liked a particular staff member, they had reported this to the registered provider, who had taken action so the staff member no longer provided their support.

We saw from care files that people's independence was promoted wherever possible. One staff member told us how they encouraged people to be as independent as possible by, "Talking to people and encouraging them; just helping them where needed." They gave specific examples, such as ensuring they did not take over the cooking with one person, because they were aware this would take their independence away. They told us that instead they guided the person where needed and allowed them to do as much for themselves as possible. Relatives we spoke with gave examples of how staff promoted people's independence. For instance, one relative told us that staff encouraged their relative to wash their own face and another told us that staff encouraged their relative to use their walking frame and stair-lift.

People told us that staff always maintained their privacy and dignity, especially when providing support with

personal care, such as bathing and washing. People told us, "They support me with personal care and always maintain my dignity" and "At the moment I'm unable to get into the bath and they are very respectful." Others told us, "Absolutely [they respect my privacy and dignity]. I'm afraid they'd be through the door if they didn't!" and "They don't come in the shower with me unless I call them; but they're in there if I need them. They do call out and ask me if I'm okay." Relatives we spoke with also confirmed that staff respected people's privacy and their comments included, "When they get [Name] in the shower, they like a bit of privacy. They are sat down on a seat, but the carers just leave them and go outside the bathroom door to keep their privacy" and "They cover [Name] up while they are sat on the bed and things. They always close the doors."

The mission statement within Flexicare at Home's employee handbook stated the expectations of staff in relation to maintaining people's privacy and dignity. Staff we spoke with understood the importance of respecting people's privacy and dignity and were able to explain how they put this in to practice. They gave examples such as respecting people's preferences in relation to bathing, keeping curtains closed and covering people when providing personal care.

Discussion with staff indicated that there people using the service that had needs in respect of the seven protected characteristics of the Equality Act 2010: age, disability, gender, marital status, race, religion and sexual orientation. Most people who used the service could potentially be at risk of discrimination due to age or disability, but we saw no evidence to suggest that anyone was discriminated against and no one told us anything to contradict this. Information about people's religious, cultural or personal beliefs was recorded in their care plan and the registered provider had an equality and diversity policy and a human rights and mental capacity policy which were shared with staff. People's right to practice their beliefs, religion or culture without constraint by restrictive or discriminatory practice was included in the service user guide. This was given to all people when they started to use this service, with details of how to raise complaints in relation to this if required.

Staff told us how they responded to people's different communication needs, including those who did not use speech as their main form of communication. For example, staff were able to tell us about the gestures and non-verbal communication one person used to express themselves and were aware that detailed information about how to interpret this person's body language was available in their care file.

At the time of our inspection, two people who used the service had an advocate. Information about advocacy was available in the service user guide and we were told that if staff identified anyone else that would also benefit from an advocate, the registered manager would contact social services to work with them to access advocacy provision. Advocates help to ensure that people's views and preferences are heard. The registered manager told us that where people did not have relatives, Flexicare at Home also supported people to access a range of other information and services where the person needed this. This included accessing welfare benefits and support to organise window and gutter cleaners. This showed that the registered provider was flexible and holistic in their approach to supporting people.

Good

Is the service responsive?

Our findings

All of the people who used the service had a care plan, which they had been involved in developing. People were aware they had a care file in their home and told us that staff wrote in this at each visit. The registered provider completed an assessment of people's needs, prior to supporting them. The information formed the basis of the care plan, which was developed when people started to use the service. Care plans included information about people's current situation, goals and outcomes to be achieved and the support required from staff. There was also further information about people's needs and individual preferences in a service delivery plan which was completed for each person. This included the person's routines, the key tasks required of staff and a breakdown of how the person wished to approach each task or activity. Staff were matched to people's preferences, and if it was identified that a staff member was not compatible the registered provider ensured that they no longer provided care to that person.

We found that each person's care package was reviewed every three months, or sooner if someone's needs changed. The care plan documentation, including the service delivery plan and risk assessments, were updated accordingly at the review. At least two of the reviews per year were conducted on a face to face basis, and the other two interim reviews could be conducted with the person over the telephone, if there were no significant changes.

Staff had the information they required to provide a personalised and responsive service. The care file in people's home contained a copy of the care plan, service delivery plan and risk assessments for staff to refer to. The file also contained a daily communication log, in which staff recorded information about the support provided during each visit, as well as medication records and a range of monitoring documentation where this was required for individuals. These included nutritional intake records, bowel and urine monitoring, weight and repositioning charts, and monitoring of domestic tasks completed. These records were regularly returned to the office and we saw that the care coordinators checked these records to identify any concerns and monitor that care was being delivered in accordance with the care plan.

Any issues or concerns identified by staff during their care visits were recorded on the communication log and reported to staff in the office, so that they could respond appropriately and log the information on their computer system. Concerns or actions remained 'active' on the computer system until they had been completed and resolved, so the registered manager was able to monitor any outstanding actions.

The records we viewed, and feedback from people and relatives, showed us that staff were person centred in their approach and flexible according to people's needs. People told us, "They fit in to whatever I need. I ring the office [if I want to change a care visit] and try to give them a week's notice and they are very amenable" and "[Care manager] would come and see me if I needed to change anything with my support package. I have review meetings." A relative told us, "It's personalised, yes. Some of the carers will do bits of shopping for [Name][in their own time]… They seem to go that extra mile for her."

People told us that staff supported them to pursue social activities and access community facilities where this was part of their care package. Comments included, "I go shopping once a week for two hours and they

[staff] take me wherever I want to go," "I've been taken to the garden centre for afternoon tea and plants. Yes, I get taken out when I need it" and "They [staff] take me to where I'm going, whether it's my friend or my [relative]. They'll leave me and then come back for me." Another person told us, "I put off having care for years, but I'm so glad I did. It has changed my life for the better. I hadn't gone out or done anything for a long time, but now I go out. Carers take me to a day centre for instance; they take me and pick me up. They are absolutely brilliant and it's changed my life."

The month prior to our inspection the registered provider had added the role of 'events manager' to the responsibilities of one of the office based staff, and told us they planned to have monthly events. The registered provider also gave us examples of how they promoted activities for people at home. For example, the Christmas prior to our inspection, they had given 24 people adult colouring books and pens.

There was a complaints, suggestions and compliments procedure in place and a system to record and respond to complaints. The policy was available to people who used the service in their care file in their home and within the service user guide, which was given to people when they started to use the service. Records showed that no formal complaints had been received in the year prior to our inspection. There were lots of thank you cards and compliment cards and letters on display in the office. The registered manager agreed to start dating any compliments cards received, in order to show which were recent and monitor any trends in the feedback received over a period of time. They told us any minor or informal concerns or issues raised were recorded in care review records and we saw examples that showed us these issues were addressed.

Although no formal complaints had been raised recently, people we spoke with told us they knew how to raise a complaint and would feel very comfortable doing so. People also told us that where they had raised concerns in the past the issue had been dealt with to their satisfaction. People told us, "I'd just ring them up and say whatever," "I would ring the owner of the firm," and "I made it quite clear at one point that I wasn't happy with certain carers and they've now left." Another person told us, "I would just phone the office. I would feel comfortable doing this because I think they'd know it wasn't malicious and that it was just a concern. I haven't needed to do this though, but would feel able to and think they would sort it out." Comments from relatives included, "I haven't had to complain, but I do know how to" and "I do know how to complain. I've only had to complain once and that was over a carer." They confirmed that they were happy with the response they had received.

This showed us that feedback and complaints were encouraged and that there was a system in place to respond to complaints.

Good

Is the service well-led?

Our findings

The service had a registered manager in post. The registered manager understood their role and responsibilities. There were also three care managers, who each had responsibility for the care packages in their designated areas and supervised a team of carers. The care managers completed assessments and care reviews, and also covered care visits where required, as part of their core role. This was because of the registered provider's expectation that the management team should know and understand the needs of all people who received a service. There were also care coordinators, who supported the care managers by completing some of the staff observations and by checking care monitoring documentation, in order to monitor the quality of service provided.

People knew the registered manager and care managers, and told us they were approachable and sometimes visited them. One person told us the management of the service was, "Very good because the manager comes and talks to me. They take a stint at what the girls do [providing care]." Others told us the management of the service was, "Fine" and "Very good, excellent. I think it's very well organised." People told us it was easy to contact staff at the office, and their comments included, "I've only to say it's me and they chat away. I'm part of the furniture now" and "I have the telephone number and there's always someone on the other end."

We spoke to staff about the management and leadership of the service. One staff member told us, "I think it's is really good and very supportive. I always know who to go to and there is an open-door policy. I have spoken to them about things and they have dealt with them in a discreet way. Other staff told us, "I go to my care manager with anything. They will support even if it is not work related things," "They are fabulous, all very approachable" and "I can't fault them… It's a well-run service." Two staff told us that the strong person centred ethos of the organisation and expectation of providing a high quality and flexible service had an impact on their own personal lives at times and could be tiring, but felt that people received a good service as a result. One told us, "I am proud to work for Flexicare." Some staff also commented that the recruitment of some additional care staff would be beneficial, in order to order to relieve the pressure when there was staff sickness and to meet the demands of providing a flexible and responsive service. However, they were aware that the registered provider had an ongoing recruitment campaign to replace care staff leaving the company and find new care staff for care packages on the registered provider's waiting list. They also told us that people's care needs were always met.

Staff told us that the culture of the organisation was open and friendly. They described the values of the organisation as, "Always putting clients first" and "Client orientated, going way above and beyond for clients." Another staff member told us the values were, "Staff and client focussed; all clients getting independence, quality of care, consistency, respect and dignity. They also try to marry the client with the carer by matching their knowledge and experience." One staff member told us the values of the organisation were, "Fantastic. What they stand for and are trying to achieve is fantastic."

This showed us that the service promoted a positive and person-centred culture.

Staff received regular supervision and appraisal, in line with the registered provider's policy. Care staff meetings were held whenever there was significant information or changes that needed to be discussed as a group, and staff received regular updates from the office in the meantime. Staff told us, "We are up to date on our appraisals and can speak to managers any time" and "We haven't had a team meeting for a while, but I do go to them. The last one we had, four of us had the meeting in the evening because we were on the rota to provide care during the day, and [registered manager] repeated the meeting in the evening for us; so they make sure everyone gets chance to go." Staff were able to request annual leave and other unavailability via a computerised system accessible on the internet.

In the Provider Information Return, submitted by the registered provider prior to the inspection, they told us they kept up to date with best practice through their membership of UKHCA (United Kingdom Homecare Association) and by being signed up to a number of regular social care publications. They also subscribed to an external company who provided updates on changes to key policies and procedures and told us they regularly reviewed publications on the CQC, Social Care Institute for Excellence and Skills for Care websites. Latest updates were presented at staff meetings or via email. The registered provider also demonstrated a commitment to sharing good practice beyond their own staff team, by making their training available to other people in the community whenever they had spare availability on courses. For example, their training had been accessed by relatives, personal assistants (carers employed directly by disabled or older people) and health champions in the local community (volunteers working with carers). The registered provider had also been invited to speak at the Skills for Care Annual Conference and a regional conference.

Due to feedback from people who used the service, the registered provider no longer sent out annual service user satisfaction surveys, and instead collated an analysis of feedback on people's satisfaction with the quality of the service from the quarterly review meetings. They told us this enabled them to respond more promptly to any issues that were raised. The analysis of satisfaction levels from 2015 reviews showed very positive feedback. We saw examples which showed us that feedback gathered in review meetings had been followed up where necessary. People and relatives confirmed they were asked their opinion on the service they received during their care review meetings. Suggestion forms were available in people's care file in their home so that people could make comments or suggestions about the service. There was also a suggestions box and forms in the office reception for staff, visitors or people to use if they wished to.

As well as feedback from care reviews, the registered manager conducted quality audits to measure the delivery of care. They audited staff files, staff training and the out of hours call log, and regularly checked that staff observations, appraisals and care reviews were up to date. The registered manager read all care reviews and staff appraisals in order to monitor any trends. There was also a system in place to check monitoring and medication records when they were returned to the office, and address any concerns identified. The registered manager told us they had created a new operations manual in the three months prior to our inspection, which incorporated new computerised features that facilitated recording and analysis.

People who used the service that we spoke with expressed a high level of satisfaction about the service they received. Comments included, "I couldn't be looked after any better," "I'm totally happy" and "I have no complaints at all." A relative told us, "It is very good as far as I'm concerned. I've got no qualms at all about the carers or the service."