Eldercare (UK) Ltd

# Eldercare UK LTD

## Inspection report

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## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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

# Summary of findings

## Overall summary

The inspection visit took place on 05 July and was announced. This inspection was the first inspection since the service was registered with the Care Quality Commission (CQC) on 20 July 2017. The service was previously registered at a different address where we inspected on 4 February 2016. At that time we found the service to be compliant with regulations and rated it overall 'good'.

Eldercare is a domiciliary care agency. It provides personal care to people living in their own houses, flats in the community and specialist housing. It provides a service to older adults, younger disabled adults, and children. People's care and housing are provided under separate contractual agreements.

Not everyone using Eldercare receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do provide any wider social care we also take this into account. CQC does not regulate premises used for people supported in their own homes; this inspection looked at people's personal care and support. At the time of the visit there were 31 people who used the service.

The service had a registered manager however they were not present at the time of the inspection visit. 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 were policies and procedures on how the service protected people against bullying, harassment, avoidable harm and abuse. Care staff had received training in safeguarding adults and knew how to report concerns. Staff had sought advice from other health and social care professionals where necessary. There were risk assessments which had been undertaken. Plans to minimise or remove risks had been drawn up and reviewed in line with the organisation's policy. These were robust and covered specific risks around people's care and specific activities they undertook in a person-centred manner.
We received significantly positive comments from people about the caring nature of the staff team.

There was a medicines policy in place and staff had been trained to safely support people with their medicines.

The service had recruitment policies and procedures in place to help ensure safety in the recruitment of staff. These had been followed to ensure staff were recruited safely for the protection and wellbeing of people who used the service. Records we saw and conversations with staff showed the service had adequate care staff to ensure that people's needs were sufficiently met. Staff had visited people at agreed times.

Staff skills knowledge, training and support demonstrated a commitment to providing a good quality of care.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. However; knowledge and application of the mental capacity principles required further improvements. The care manager informed us people's consent was sought. However, care records did not demonstrate how mental capacity had been considered. We have made a recommendation about staff knowledge and understanding on the subject of mental capacity and best interests' decisions.

Care plans were in place detailing how people wished to be supported.

We found people had been assisted to have access to healthcare professionals and their healthcare needs were met.

People who used the service and their relatives knew how to raise a concern or to make a complaint. The complaints procedure was available and people said they were encouraged to raise concerns.

The registered manager used a variety of methods to assess and monitor the quality of service provided to people. These included regular internal audits of the service, surveys and staff and review meetings to seek the views of people about the quality of care being provided.

## 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

This service was safe.

People and their relatives told us they felt safe. Feedback was positive. Staff had received safeguarding training and knew how to report concerns.

Risks to the health, safety and well-being of people who used the service were assessed and plans to minimise the risk had been put in place.

People's medicines had been safely managed. Staff had been trained in the safe administration of medicines.

Staff had been safely recruited and disciplinary measures were in place.

### Is the service effective?

Good

This service was effective.

There was a policy on mental capacity and seeking consent. However; improvements were required in relation to the understanding of mental capacity principles and its application in the service. Staff had not received ongoing mental capacity training

Staff had received training, induction and supervision to ensure they had the necessary skills and knowledge to carry out their roles safely.

People were adequately supported with their nutritional needs.

People's health needs were met and specialist professionals were involved appropriately.

## Is the service caring?

Good

The service was caring.

People and their relatives spoke highly of care staff and felt their family members were treated in a kind and caring manner.

People's personal information was managed in a way that protected their privacy and dignity.

Staff knew people and spoke respectfully of the people they supported. The service supported people to express their views and to make choices.

People's independence was promoted.

## Is the service responsive?

Good

The service was responsive.

People had records of care which included essential details about their needs and outcomes they wanted to achieve. Records were comprehensive and detailed.

There was a person-centred approach to care planning and care was reviewed regularly with people and their relatives. People were able to give feedback about their care services and staff who supported them.

There was a complaints policy and people's relatives told us they felt they could raise concerns about their family member's care and treatment.

Good

### Is the service well-led?

There was a registered manager in post. People gave positive feedback about the company.

Feedback from staff regarding management and the culture in the service was positive. Staff had been provided with oversight on their role.

People and their relatives had been consulted about the care provided.

Policies for assessing and monitoring the quality of the service were in place.

# Eldercare UK LTD

## 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 site visit took place on 04 July 2017 and was announced.

We gave the service 48 hours' notice of the inspection visit because it is domiciliary care service and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

We visited the office location on 04 July to see the manager and office staff; and to review care records and policies and procedures.
The inspection team consisted of one inspector and an assistant inspector.

Before our inspection visit we reviewed the information we held on the service. This included notifications we had received from the provider about incidents that affect the health, safety and welfare of people who used the service. We also reviewed the Provider Information Return (PIR) we received prior to our inspection. This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. This provided us with information and numerical data about the operation of the service.

During the inspection we spoke with nine people who used the service or their main carers over the telephone. We received feedback from two staff via email and spoke to two staff on the phone. We spoke with the care service manager. After the inspection we spoke to the nominated individual who is also the registered manager for the service.

We looked at care records of five people who used the service, training records, three recruitment records of staff members and records relating to the management of the service. We also contacted the safeguarding department at the local authority.

Good

# Our findings

We asked people who used the service whether they felt safe receiving care from the service. All people we spoke with told us they felt safe. Examples of comments included, "Yes, I've three carers normally. They are brilliant, no problem at all. Three of the best (carers) I could ever have", "The staff come in pairs, I feel anxious when there is a new member of staff but, yes on the whole I feel safe." And; "I really feel safe with the staff in the house because they send the same people and that's what we like." Similarly, relatives we spoke with were positive, "We had a little hiccup at the beginning but that was soon sorted and they took our advice on board and listened."

The registered manager had procedures in place to minimise the potential risk of abuse or unsafe care. All staff had received safeguarding training. There were no safeguarding incidents that had occurred in the service. However, care staff we spoke with were able to demonstrate that they had knowledge on how to report concerns if they suspected people were at risk of exploitation or harm. Safeguarding procedures had been reviewed regularly and training continued to be updated for staff. One staff member told us "We have duty of care to report any form of abuse and will report any concerns to the registered manager."

There were arrangements for reviewing and investigating safety and safeguarding incidents and events when things went wrong. Staff were aware of the signs of abuse and discussed the appropriate actions they would take if abuse was suspected. They said, "Any concerns I would inform the office, so that they can inform social services to investigate." Staff told us they had no concerns about the care people received and were aware of the whistleblowing policy (reporting bad practice). They told us they would feel confident reporting any concerns to the registered manager. Comments included, "I have no concerns

about the care or the service" and, "I trust that anything I raise with managers would be kept confidential." We felt reassured by the level of staff understanding regarding abuse and their confidence in reporting concerns.

Risks to people were assessed and their safety was monitored and managed so that they were supported to stay safe and their freedom is respected. We looked at how the service protected people against risks of receiving care and treatment. There were risk assessments in people's care files which included risks of malnutrition, falls, medicine misuse, moving and handling, personal care and environmental risk assessments, such as people's security in their homes.

Care files we checked demonstrated that people's risks had been assessed, documented and reviewed regularly when there was a change. Risks had been clearly identified and staff had been provided detailed guidance on how they could ensure risks to people were reduced. For example, in one person's records staff had been clearly guided to take extra caution when supporting the person to reduce the risk of infection and cross contamination. In another example one person had been assessed to be at high risk of poor outcomes due to their specific health needs. Care staff had been given specific instructions to ensure they observed dietary requirements and pay attention to how the person presented on each visit. This meant that the service had identified people's risks and put measures in place to minimise them. All records we reviewed were accurate, complete, legible, up-to-date, securely stored and available to relevant staff so that they support people to stay safe.

Where people required equipment to assist them with their mobility, turning or transferring in bed, staff had clear guidance to check the safety of the equipment and to ensure the equipment was safe to use.

We spoke with people who used the service and relatives about the support they received with their medicines. People said they received their medicines when they needed them with the correct amount of support. Staff told us and records confirmed they had undertaken the required training in the safe administration of medicines. We saw evidence of 'spot checks' undertaken by management to observe staff providing people with support. These are visits carried out by management to monitor how staff delivered care in people's homes. This helped to ensure staff had the required knowledge and skills to support people with their medicines safely.

We saw the provider had an up to date and robust policy and procedure to guide staff on the safe administration of medicines. Records we reviewed showed people were supported to take their medicines safely. Medicine Administration Records (MAR's) confirmed medicines had been administered as prescribed and signed by staff.

We saw that the service had undertaken regular audits of completed MAR sheets. This helped to ensure people's medicine administration was monitored and checked for any gaps. The care manager told us all MAR sheets were returned to the office and safely stored.

Records of medicines support had details of how medicines were stored safely to protect people from the risk of misadministration. Where concerns had previously been identified in relation to the administration of medicines, we saw actions had been taken by the registered manager and staff to ensure any future risks of medicine errors were reduced.

We looked at recruitment processes and found the service had recruitment policies and procedures in place, to help ensure safety in the recruitment of staff. We reviewed the recruitment records of three staff members and found that robust recruitment procedures had been followed. We saw the required character checks had been completed before staff worked at the service and these were recorded. The files also included proof of identity and Disclosure and Barring Service (DBS) checks. The DBS carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruitment decisions.

The service employed enough staff to carry out people's visits and keep them safe. Staff we spoke with told us they had enough time at each visit to ensure they delivered care safely. People we spoke to informed us staff supported them at a safe pace without feeling rushed. One person told us, "Yes we have enough staff and they stay for half an hour, most definitely. They chat to me and explain to me." And, "They don't rush me."

During the inspection we looked how staff logged in and out for visit. We found staff had visited as planned. People told us the service had been reliable and that in the majority of cases staff had visited as planned. They also told us that they saw the same staff unless there was a specific reason for not doing so, such as annual leave or sickness. One person told us, "Yes most definitely, always on time. I can set my clock with them. If they are late it's for a reason and ring to say they are will be late. I always know where they are." The manager told us that some people have two regular workers to ensure familiarity and consistent care.

We asked staff if they felt they had enough time to provide care and travel to their next visits. They told us they were given enough time with people, were given time for travelling and that visits to people did not overlap. People we spoke to told us that staff stayed for the allocated time.

We looked at how the service minimised the risk of infections and found staff had undertaken training in infection prevention and control and food hygiene. There were policies and procedures for the management of risks associated with infections. People told us staff wore their uniforms and gloves and disposed used gloves appropriately.

A business continuity plan had been developed, which helped to ensure continued service in the event of a variety of emergency situations, such as flood, severe weather conditions, flu pandemic or power failure. Staff were aware of actions they needed to take in the event of a medical emergency, such as a person collapsing or if there was no response when they visited someone in the community, who they would have been expected to be at home. There was a lone working policy which provided staff with guidance to promote health, safety and welfare of lone workers. Lone workers are staff who work by themselves without close or direct supervision and in a separate location to the rest of their team or manager.

Good

# Is the service effective?

## Our findings

People who used the service and relatives we spoke with told us they were confident that staff had the knowledge and skills to meet their needs. Comments included, "Yes they know what they are doing", "It's a great service. They give me the service I ask them to give me" and "They are knowledgeable and always turn up on time."

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 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. The application procedures for this in community services such as people receiving services in their homes and supported living are called the Court of Protection authorisation.

We reviewed how the service gained people's consent to care and treatment in line with the MCA. One person told us, "Staff will ask my consent before they help me with anything."

The care staff we spoke with demonstrated an understanding of the legislation as laid down by the Mental Capacity Act (MCA) 2005. However, records of training showed that staff had not received ongoing MCA training. In addition, we found four of the records we reviewed did not have mental capacity assessments when people involved had an impairment of the mind which had an impact on their decision making. We spoke to the manager and they explained that they would complete mental capacity assessments for all individuals where people's ability to make specific decisions was likely to be impacted by an illness. They also informed us that people they support would have been assessed by other professionals before agreeing to use their service. However; the provider is required by law to complete mental capacity assessments and best interests' processes for people who have an impairment of the mind before providing care support. This meant that knowledge and awareness of the mental capacity practice and principles needed further improvement.

We recommend that the service sources more training for staff, based on current best practice, in relation to the application of mental capacity principles.

We saw people's needs and choices had been assessed and care, treatment and support delivered in line with current legislation apart from MCA, standards and evidence based-guidance to achieve effective outcomes. For example, people's preferences, intolerances and allergies had been recorded and shared with relevant staff. We observed staff following guidance and recommendations from specialist professionals to support people. For example, we reviewed records of one person who had specific dietary needs.  Staff supported them with their meals in line with recommendations by health professionals. This meant staff had followed advice from other health professionals about people' care needs to ensure the right care or treatment was provided.

Records showed that staff completed an induction programme when they joined the service which included, shadowing experienced care staff to gain experience and staff familiarising themselves with policies such as manual handling, safeguarding vulnerable adults from abuse, confidentiality and whistle blowing. The staff we spoke with told us they had received a thorough induction when they started working at the service. They told us that as part of their induction they had been able to shadow and observe experienced staff supporting people, to enable them to become familiar with people's needs before becoming responsible for providing their care. This helped to ensure staff could provide safe, personcentred care which reflected people's needs and preferences. One staff member told us; "When I joined the organisation I was able to shadow all three teams before I was allowed to do shifts. This gave me a chance to familiarise myself with the people we support."

There was a training plan in place which identified training that had been completed by staff and when further training was scheduled or due. We noted that a significant amount of training had been completed by care staff. Some staff were due to update their training and this had been identified and schedules were in place to ensure these were completed. This helped to ensure that staff were trained and able to meet the needs of people they supported. We noted that some staff had also completed national vocational qualifications (NVQ) or were due to start the and health and social care diploma. Staff were also completing the 'Care Certificate'. The care certificate is considered to be best practice for staff members new to the care industry. The service had a manager who delivered the majority of the training for staff members. We saw a specific training room was available in the office.

Records showed that staff received regular supervision. Care staff we spoke with confirmed this to be the case. They had also received on site supervision in the community, which was designed to monitor care staffs conduct whilst they delivered care to people in their homes. We reviewed some staff supervision records and noted that issues discussed included staff performance, standards of care, staff roles and responsibilities and training issues. Additional supervision was also provided when it was found necessary to provide staff with extra support. Staff told us they felt able to raise any concerns during their supervision sessions. One staff member told us, "[name removed and name removed] managers, usually work alongside staff every month. This gives them the opportunity to observe how we do our job and any challenges we face. This meant that the service had put measures in place to monitor staff performance and offer support where required.

Staff spoken with told us meetings were held, so the staff team could get together and discuss any areas of interest in an open forum. This also allowed for any relevant information to be shared with staff. Records seen confirmed meetings had taken place and there was significant staff turnout to meetings. We saw that during team meeting topics discussed included the importance of good time keeping and staff issues around the rota and safeguarding procedures. Guidance and changes to practice had also been shared during the meetings.

We looked at what arrangements the service had in place to ensure people received care that had been appropriately assessed, planned and reviewed. We looked at five people's care files. All five files contained assessments also known as support plans. It was evident that a full assessment of people's needs had been completed before a decision had been made about whether the service could meet that person's needs. Additional assessments were also evident in some of the files we looked at, for example assessments and service agreements completed by the Local Authority. The manager informed us that they undertook a

12step assessment process which covers all that care staff needed to know before providing support to people.  This helped to provide a more detailed and holistic assessment of people's needs.

We looked at how people's nutrition was managed. We found the provider had suitable arrangements for ensuring people who used the service were protected against the risks of inadequate nutrition and hydration. Systems and processes for monitoring people's nutritional needs were in place. People's records showed their preferences and risks associated with poor nutrition had been identified and specialist professionals had been involved where appropriate.  Precautions around people's nutrition, such as food allergies were clearly written in people's records. For example, there was guidance on dietary needs of people with medical conditions such as diabetes.

People were supported to live healthier lives, have access to healthcare services and receive ongoing healthcare support. We saw that people's healthcare needs were considered as part of the care planning process. We noted assessments had been completed on physical and mental health and there was a detailed section in each person's care plan covering people's medical conditions, their medicines and what these were for. In addition, staff supported people with hospital visits and arranging medical appointments. For example, we saw one person who regularly needed hospital visits was supported by staff to ensure they maintained their appointments. We saw evidence of staff sharing information with health professionals such as district nurses and doctors about people's conditions. Staff were monitoring any signs of deteriorating health. There were strong links with the local primary health services and professionals such as local doctors and District Nurses.

Good

# Our findings

We received numerous positive comments about the care staff and the service delivered to people. Comments included, "Oh yes, they are brilliant. I have had quite a change of workers. However, [name removed] is brilliant. They say tell me where you want to go and I'll take you. The caring that [name removed] has in her. I can't say enough about her", "I have a good relationship with my care workers" and "The staff are polite and nice.", "They are caring, they treat me with dignity and respect. They are very respectful making sure the windows are closed."

Staff had a good understanding of protecting and respecting people's human rights. All staff had received training which included guidance in equality and diversity. We discussed this with staff; they described the importance of promoting each individual's uniqueness. There was a sensitive and caring approach, underpinned by awareness of the Equality Act 2010. The Equality Act 2010 legally protects people from discrimination in the work place and in wider society.

Staff were compassionate kind and caring in their approach. One staff member told us; "We support a significant number of people who are towards the end of their life, so we are sensitive and compassionate." In addition, one person told us," [name removed] staff member, offered to take me to the urgent care centre when I hurt my knee. They also reminded me to use my pendant in the event I needed help."

Staff spoken with and the care services manager had a sound knowledge and understanding of the needs of people they cared for. Staff members told us how they enjoyed working at the service. Comments from staff included, "I like my job and I enjoy supporting people."

There were arrangements to promote people's independence and autonomy. Records we saw showed that people were being supported to be as independent as possible, in accordance with their needs, abilities and preferences. People were encouraged to do as much as they could for themselves. For example, the manager informed us some people manage their own medicines and only require support with creams and some regular prompts. In another example the service had supported one person to maintain social contact and attend church regularly. Staff explained how they promoted independence, by enabling people to do things for themselves. In their PIR the registered manager wrote; 'We know that each and every one of our service users are individuals with skills and assets to be built upon, and we work tirelessly with our service users to ensure that they get the best out of life, and share those skills wherever possible.'
One staff member said, "We encourage people who have independent living skills to do as much as they can." We saw a testimony written by one person who used the service, they said; "The care workers have respected me, shown empathy and have always been respectful in all aspects of care."

Daily records were completed by care staff and were written with compassion and respect. All staff had been instructed on maintaining confidentiality of information and gave us examples to demonstrate that they understood the procedural guidance. People's records were stored securely. This meant people using the service could be confident their right to privacy was respected with their personal information kept in a confidential manner. In their PIR the registered manager had reiterated that; 'The privacy, dignity and independence of each individual is respected, taking into account their personal wishes and circumstances Care and support are provided with due regard to each person's age, sex, religion, race, sexual orientation, culture, language and ability.'

Staff we spoke with showed a clear understanding of the measures in place to ensure a person's privacy and dignity was respected and gave appropriate examples. They told us they understood that their place of work was someone else's home and had to be respectful. They knocked before entering, even when they had used a 'key safe' to enter the house. A key safe system is a system where a key is stored in a secure box outside of the property. Comments from people included, "Yes, they always knock before they come in", "We have never had a bad thing to say. They have been really helpful." And, "They are polite. One kneels down near me to get to my level."

The care provided was designed to support people to express their views and be actively involved in making decisions about their care. Records we saw clearly demonstrated that people's views on the care they received was sought. People could choose the levels of support and times that suited them. There was information available about advocacy. Advocates support people to access information and make informed choices about various areas in their lives. Relatives that we spoke with informed us that they had been involved in the care of their family members and that this had improved the quality of the care they received. The care staff we spoke with displayed a real passion in relation to the care of people and it was evident that the ethos of the service was based on the care and compassion of the people using the service.

Good

# Our findings

We received positive feedback from people using the service and their relatives. Comments included, "The care staff are brilliant", "It has got better they respond and listen to our advice", "The care staff sometimes have to change their plans if I need to go to hospital or if my appointments change, they are flexible" and "You couldn't find a better company that respond to your requests."

However, one person informed us they were worried about a proposed change to how staff were allocated. They felt they will lose consistency and rapport they had with their existing carers. We shared their views with the manager who informed us that they would ensure all changes to rotas were communicated with people and that disruptions to people's routines will be limited.

We looked at how the service provided personalised care that was responsive to people's needs. We found assessments had been written in a person-centred manner and were detailed. Care plans were comprehensive, contained people's identified needs, the outcomes they wanted to achieve and guidance to staff on what to do on arrival to people's houses and the order in which people preferred their care to be delivered.

We also noted that people had been involved in their assessment and where appropriate, the service sought support from their family members. Daily reports provided evidence to show people had received care and support in line with their care plan. We noted that records were detailed and people's needs were described in respectful and sensitive terms.

Procedures were in place for the monitoring and review of care plans. Care plan reviews were carried out regularly. At each review there was an overall assessment of each person's progress or circumstances and whether they have been achieving their goals. People's care could also be reviewed as deemed necessary depending on their needs. During the reviews input from other professionals was also reviewed and where additional support was required from specialist health care professionals, this was arranged. One person said, "Yes the care plan has just been redone when I came out of hospital.' A manager came out and included me in the reviewing of the care plan." However, five out of nine people told us they were not aware of their care plans and if they were reviewed. Following the inspection, we informed the registered manager who advised that they would ensure review visits are clearly communicated with people when they happen.

Some of the people supported by the staff used assistive technology to summon for help and to monitor risks of falls. The provider had a service of emergency responders who visited people if they experienced a fall or an emergency at home and required assistance. Staff shared care records via email in some

instances and additional technology was being considered to monitor staff visits. This meant the provider had responded to the need to modernise their practices in line with technological advances.

We looked at the policies and procedures that the provider used to check if staff were staying the allocated time and visiting as planned. In one of the localities, there was a log in and log out system for which staff used to demonstrate the time they arrived and the time they would have left people's house.

We found that staff were staying the duration. However, in another locality the service was not monitoring the times when staff visited or finished duty. We spoke to the care manager who informed us this was because the management would work with staff in some instances and monitor them. The lack of monitoring systems meant that the provider was unable to proactively monitor whether people were receiving their visits as planned. We would expect the service to establish a system for monitoring staff visiting times. The manager informed us that they would review this and consider introducing technology to assist with this.

We asked staff if they felt they had enough time to provide care and travel to their next visits. They told us they were given enough time with people, were given time for travelling and that visits to people did not overlap. People we spoke to told us that staff stayed for the allocated time.
We checked if the provider was following the Accessible Information Standard. The Standard was introduced on 31 July 2016 and states that all organisations that provide NHS or adult social care must make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need. We looked at how the service shared information with people to support their rights and help them with decisions and choices. We saw in the letters sent to people they were given a choice if they wanted other formats of such as braille or large print. We found there was information in people's care plans about their communication skills to ensure staff were aware of any specific needs. We would now expect the provider to incorporate the practices into their policies to ensure consistency.

The service had a complaints procedure in place. The procedure provided directions on making a complaint and how it would be managed. This included timescales for responses. There had been no complaint received since our last inspection.

Staff we spoke with confirmed they knew what action to take should someone in their care, or a relative approached them with a complaint. This meant that people could be assured that their concerns would be dealt with appropriately. People we spoke with confirmed they were aware of the complaints procedure and how to access any information around making a complaint. They told us they were confident should they have any issues that these would be dealt with appropriately. One person said; "I have not made a complaint but I know how to contact Eldercare if I need to." And, "If I have any concerns they always sort it and get back to me. They've always done that."

Records we saw demonstrated that the provider and the staff had taken into consideration people's preferences and choices for their end of life care. For example, there was a policy which guided staff to record where people wished to die, including in relation to their protected equality characteristics, spiritual and cultural needs. There was also guidance on communicating with families and professionals to support people towards the end of their life. The service provided support to people who were towards the end of their life. However, care files did not always contain details of how people wished to be cared for in the

event of death or terminal illness. The manager informed us that they always worked closely with a local hospice and community health workers who were able to provide staff with guidance and resulted in an appropriate care plan. This would assist in ensuring that people were supported at the end of their life to have a comfortable, dignified and pain free death.

# Our findings

We received positive feedback about the management and leadership of the service. People told us, "The Company is very good I cannot grumble", "Very good company, I could recommend them" and "The office staff are brilliant." Staff were complimentary about the registered manager and the management team. They told us, "[Name] is great as a manager." They told us they were supported to develop their skills to undertake their jobs effectively.

The service was led by a manager who was registered with the Care Quality Commission. The registered manager had responsibility for the day to day operation of the service. There was a clear leadership structure in place within the organisation. All staff we spoke with were aware of their roles and responsibilities as well as the lines of accountability and who to contact in the event of any concerns while undertaking their duties. There were up to date policies and procedures relating to the running of the service. Staff were made aware of the policies at the time of their induction and when new changes came into place.

The registered manager was not present at the time of our inspection visit. The care service manager was providing leadership in their absence. We spoke with care service manager about the daily operations of the service. They understood their role and responsibilities and understood the operation of the service. This included what was working well, areas for improvement and plans for the future. The registered manager was supported in their role by a care service manager and a care coordinator.

We found evidence to demonstrate that there was management oversight from the registered manager. For example, staff with delegated tasks had been supervised by the registered manager and discussions had been undertaken on what was expected of the staff and how progress was going to be monitored. Staff had been made aware who they were accountable to. This meant that the service had arrangements in place to ensure staff had clear guidance and lines of accountability.

There were quality assurance systems and tools in place. We saw surveys had been carried out to seek people's views and opinions about the care they received. People were also asked to share their views about care staff and the feedback was positive. Where concerns had been raised action was taken immediately.

We found managers in the service had visited people to review their care and also seek their views on the care they received. The care services manager told us and records confirmed how they monitored the quality of service. These included monthly medicines and care files audits, and people's daily records. 'Spot checks' had been undertaken to observe staff's performance on a regular basis. These were in place to check that staff were punctual, stayed for the correct amount of time allocated and the people supported were happy with the service. There was evidence of the measures taken by the provider as a result of the findings from the audits.

We looked at how staff worked as a team and how effective communication between staff members was maintained. Communication about people's needs and about the service was robust. We saw evidence to demonstrate that the service had adopted to keep up with best practice. We found meetings, memos and modern technologies were used to keep staff informed of people's daily needs and any changes to people's care. Information was clearly written in people's daily records showing what care was provided and anything that needed to be done on the next visit.

We also found a handover system was in place to ensure information relating to people's care was shared between care staff and staff located in the office. For example, information relating to changes in people's care visits was shared via telephone or secure email system. In addition, there was a 24hr management on call system. This ensured that staff who worked at night would receive leadership and guidance if they needed this at any time.

Regular staff meetings had taken place and records showed they had been kept up to date and were listened to. Staff were provided with job descriptions, a staff handbook, contracts of employment and had access to policies and procedures which would make sure they were aware of their role and responsibilities.

We checked to see if the provider was informing the Care Quality Commission (CQC) of key events in the service and related to people who used the service. At the time of this inspection there had not been any notifiable events in the service. We saw there was a policy which reminded staff when to submit a notification. A notification is information about important events which the service is required to send us by law.
We found the organisation had maintained links with other organisations to enhance the services they delivered, this included affiliations with organisations such as local health care agencies and local commissioning group, pharmacies and local GPs.