Optalis Limited

Short Term Support and Rehabilitation Team

Inspection report

Town Hall
St Ives Road
Maidenhead
Berkshire
SL6 1RF

Tel: 01628621981
Website: www.optalis.org

Date of inspection visit:
07 November 2017
08 November 2017

Date of publication:
21 December 2017

Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

Our inspection took place on 7 November and 8 November 2017 and was announced.

This is our first inspection of the service because the provider of the service changed in April 2017.

The Short Term Support and Rehabilitation Team provides intermediate care to people recovering from injury or illness that require rehabilitation. The service also prevents unnecessary hospital admissions and provides palliative care. This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to adults. Only personal care is regulated by us, and our inspection has excluded evidence about other support types offered by the service. Based in the Maidenhead Town Hall, the service only provides support to residents of the Royal Borough of Windsor and Maidenhead. At the time of our inspection, 58 people used the service and there were approximately 40 staff.

The service is required to have a registered manager as part of their conditions of registration with us. 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. At the time of our inspection, there was no registered manager. However, the manager had made an application to register with us, which was in progress.

People were protected from abuse and neglect. We found staff knew about risks to people and how to avoid potential harm. Risks related to people's care were assessed, recorded and mitigated, although sometimes information was not detailed enough. We made a recommendation about the way people's care information is recorded. We found appropriate numbers of staff were deployed to meet people's needs. People's medicines were safely managed.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted to have maximum choice and control of their lives and staff supported them in the least restrictive way possible. The policies and systems in the service supported this practice.

Improvement in the amount of staff training, supervision and performance appraisals was required to ensure workers had the necessary knowledge and skills to effectively support people. There was collaborative working with various community healthcare professionals.

The service was caring. There was extensive complimentary feedback from people who used the service. People told us they were able to participate in care planning and reviews and some decisions were made by staff in people's best interests. People's privacy and dignity was respected when care was provided to them.

Care plans were person-centred and contained information of how to support people in the right way. We saw there was an appropriate complaints system in place which included the ability for people to contact any office-based staff member or the management team. People and relatives told us they had no current concerns or complaints. We made a recommendation about the collection of feedback from people, relatives and stakeholders.

Accidents and incidents were not recorded in a consistent method and an accurate number of events could not be provided. Provider-level methods of good governance such as audits were not implemented at the service and the quality and safety of the service could not be adequately measured. A small number of service-level checks of the quality of care were in place, and this included a continuous action plan. Regular management and staff meetings were used to share important information. There was a positive workplace culture within the service.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's risks were recorded, but further improvement is required.

People were protected from abuse or neglect.

There were adequate staff deployed to meet people's needs.

Is the service effective?

Requires Improvement

The service was not always effective.

There was a fragmented system for recording and storing people's care records.

There were insufficient levels of staff training, supervision and performance appraisals.

People's consent was obtained and best-interest decisions were made when a person's capacity was impaired.

People benefitted from the service's commitment to ensuring good access to community-based healthcare.

Is the service caring?

Good

The service was caring.

People told us staff were patient and kind.

People had developed positive relationships with staff.

People were encouraged to participate in care planning.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care was personalised and tailored to their needs.

People's care was reviewed and changed, when required.

People knew how to make a complaint.

The service managed complaints appropriately.

Is the service well-led?

Requires Improvement

The service was not always well-led.

People's accidents and incidents were recorded in different ways and not able to be readily collated, analysed and learnt from.

Systems used to ensure good governance of the service required improvement.

Staff and management meetings were effectively used to ensure the quality of care.

There was a positive workplace culture within the service.

Short Term Support and Rehabilitation Team

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.

Our inspection took place on 7 November and 8 November 2017 and was announced.

Our inspection was completed by two adult social care inspectors and an Expert by Experience. An Expert by Experience is a person who has personal experience of using or caring for someone who uses this type of care service. Our Expert by Experience was familiar with the care of older adults who receive support in the community.

Before the inspection, the provider was not required to complete a Provider Information Return (PIR). 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. The provider submitted a contact list so we could call people who used the service, staff, commissioners and others.

We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also looked at feedback we received from members of the public, local authorities and clinical commissioning group (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).

At our inspection, we spoke with the nominated individual, service manager, assistant team manager, a care coordinator, and four rehabilitation care assistants. We also spoke with the provider's health and safety coordinator and interim quality lead. We telephoned eight people who used the service and asked them

questions about the service.

We looked at 14 people's care records, four staff personnel files and other records about the safe management of the service and quality of care. After the inspection, we asked the registered manager to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Good

Is the service safe?

Our findings

We asked people who use the service if they felt safe with the support they received. Comments included, "We felt totally safe with them. We had various ones and there was [name of a rehabilitation care assistant] who was fantastic; they were all fantastic!", "Yes, they were all very nice, all of them" and "I felt absolutely safe; I can't praise them enough!"

People were protected because systems were in place to prevent abuse and neglect. The provider had appropriate policies for safeguarding and staff whistleblowing, and these were up-to-date. The service had access to a copy of the Berkshire safeguarding adults' procedures, which contained the necessary information about dealing with and reporting abuse or neglect for the region. The manager was clear about their part in managing safeguarding concerns. This showed the service was aware of procedures to protect people. We found staff inductions and routine training included the subject safeguarding.

Staff told us they had been trained in safeguarding and were familiar with the service's safeguarding procedures. All were able to provide definitions of different forms of abuse when asked and said that they would report any concerns immediately to the duty officer. They were aware of the whistleblowing and were able to outline contacts outside the provider organisation if they needed to escalate a concern, including the local authority, police and us. There was evidence of a safeguarding process in one of the person's files which was well-documented with appropriate follow up.

We saw care records contained a number of risk assessments and a functional dependency chart to assess risks related to mobility, medication, personal care and other daily tasks. These were not always very detailed and used a template with a limited list of pre-defined possible risks (moving and handling, personal care and continence, food preparation, medication, environment) with a box for identifying level of risk and space for actions required to reduce the risk. In the people's care records we reviewed, these did not always contain clear or detailed information and in some cases it appeared that there may be other risks to the person that were not outlined.

For example, we saw daily notes in one person's file referred to barrier creams being applied but there were no risks noted in relation to skin integrity. In another file the person had a catheter and stoma and needed to "develop a routine for managing" but no risks or actions for this were recorded. No behavioural risks were identified although we saw one person had consistently refused support from staff. There was no evidence of body maps. However there was clearly input from other health care professionals and different teams, for example occupational therapists, physiotherapists and district nurses. The notes did not always document which member of the multidisciplinary team provided different aspects of people's care and support .

We found that sufficient staff were deployed to safely meet people's needs. All staff we interviewed reported that they always had enough time to complete their tasks and support people safely and effectively. They said that the staff allocation system had built in flexibility so that it they were delayed or managing unexpected events or emergencies additional staff and support could be arranged to provide extra cover. Some delays to people's care were inevitable, with roadworks or heavy traffic. There was no evidence

however that people's support calls were missed. People's comments about staffing levels included, "They were late quite often. It (my care) doesn't need the full hour, but I ask them to do something else (to fill the hour)", "Only once one of the carers was late. They were caught up with someone else", "Once or twice they got called away but I didn't mind since they called me" and "They always came. There were delays; sometimes it was because of the weather and they had to cover a big patch."

We looked at safe staff recruitment. We examined the contents of four personnel files. We saw appropriate checks for new workers were completed. This included verification of staff identities, checking any criminal history via the Disclosure and Barring Service, obtaining proof of conduct (references) from prior health and social care roles, and ensuring staff were able to perform their roles. We found the service employed only fit and proper staff to care for people.

People's medicines were safely managed by staff. Not all people required assistance with their medicines, and the care plans we reviewed showed this was clearly documented. People were prompted to take their medicines and staff were required to administer medicines for others. The medicines administration records (MAR) were correctly completed. Care staff were trained in the administration of medicines and had regular competency checks. There was an appropriate medicines policy in place. We asked the manager to review the policy because the latest best practice information for medicines management in people's homes was not included.

Appropriate procedures were in place for infection prevention and control. Staff told us they received regular training on infection control, which also included information on food hygiene and this was confirmed by the training matrix we viewed, which covered infection control as part a health and safety training module. However, we not all training was up to date. Some had not had updates since 2014. We pointed this out to the manager. Staff were provided with personal protective equipment (PPE) such as disposable gloves and gowns. There were robust procedures about staff uniforms, fingernails and jewellery. All staff had access to alcohol-based hand sanitiser.

Staff reported that there was always on-call supervisory cover outside business hours, including weekends, if they needed help or support from duty officers. Staff told us they found this reassuring as they could ask for help or guidance from the on-call staff in complex situations or if a problem occurred. Staff said that learning points from accidents, safeguarding and other incidents were discussed at regular staff meetings every week where any additional concerns or queries could be raised and advice or tips relating to good practice could be shared.

Requires Improvement

Is the service effective?

Our findings

We asked people their opinions on whether the care provided by the service was effective. All of them told us the service met their care requirements. One person said, "They ask me whatever it is I want to be dressed in and things like what else they can do". Another person told us, "They treated me very well. They treated me with great respect. I was helped with physio. I was well looked after by them to get my independence but the exercises got too much". Other comments we received included, "I didn't expect the support to be that good", "I got emotional, they were so good" and "They were very good and I was very pleased with them. They encouraged one step at a time and at my own pace."

We saw care plans were handwritten at the first home visit prior to the start of service and included an assessment of risks and needs. Assessments were generally 'tick box' records and there were not detailed support plans for different aspects of care. Although there was a small section for personal care, all the plans we viewed lacked any substantial detail even where clinical needs were apparent, and there was little evidence of person-centred information such as likes, dislikes or preferences. In one care plan, daily notes recorded the application of cream but this had not been noted anywhere in the care plan.

Most individual details were contained in the front section of the care folders and related to medical history, and a section named "helpful information". This part noted some information such as communication needs, use of a catheter, stoma care required, and pain. We saw this section pertained mainly to clinical or physical needs. Daily care records were maintained on observation sheets which were kept with the care plan and completed by the staff at each visit.

Care plans were left in people's homes and no copy was kept at the office for reference. This meant that there was no information on the assessed risks and the care arrangements that had been agreed available at the office in the event of a query or concern, which could represent a risk to people. Care plans were only returned to the office once a person's care package ended and the discharge form had been completed. Care plans and daily notes were then scanned onto the computerised care system but those seen were often disordered or incomplete. For example, there were missing daily notes, the notes were not chronological and there were missing pages from person's care plan. This made it more difficult to ascertain whether the person's care was effectively assessed, delivered and adequately recorded.

We saw there was additional information, including some duplication, on people's needs that was stored electronically on the provider's other systems in the form of typed daily logs or case notes. Each person had their own file record on the computer system and this included some background information along with regular updates on progress, daily feedback if required, information from reviews, telephone contacts, and any other concerns or relevant input. However these records did not include information from the care plan or an overview of care needs or risks. Care staff were all issued with smartphones to log in and out of calls, and which they could also use to send electronic information or updates on service users to the office.

Information on service users support needs and risks was therefore not consistently ordered or maintained as it was recorded across several different systems and this meant that there was a risk that changes or

updates would not be effectively replicated across all records. In other cases there had been handwritten updates to the care plan, such as a change of visits or care tasks required but it was not possible to track this in office-based computer case notes . This meant that people were at risk of not receiving care in line with the most current assessment of their needs.

We recommend that the service reviews the systems used for staff to access the most current assessment of people's needs.

Training was organised and managed by the local authority, and the service was required to book their staff into available slots. The management team expressed some concerns about the ability to effectively obtain slots for staff. Staff indicated that they received regular training in all relevant aspects of their work and were able to give examples of recent training such as moving and handling, fire safety, first aid, medication and safeguarding. We saw the training matrix which showed the training history for staff. We noted staff were up-to-date with their training for most modules, although some had not had the required updates for dignity and respect, end of life care or health and safety (which included fire safety and infection prevention and control). We noted that fewer staff had received training in dealing with difficult people (behaviours that challenge the service) and only 50% had received training in the Mental Capacity Act 2005.

The service also provided additional training sessions at staff meetings where speakers were invited on a monthly basis to give talks on specialist areas of care such as stoma care, continence management. Staff said that they found these sessions valuable and interesting and a useful supplement to training.

Staff reported that they had regular one-to-one supervision reviews with their line managers although the reported frequency varied. We saw this was most commonly every three to six months. The supervision matrix showed that only 50% of staff had participated in supervision reviews since April 2017. Records of supervision were maintained in staff files. We found the supervision records we reviewed were very well-documented with a clear description of the discussion and any action points. There was evidence of input from both the supervisor and the rehabilitation care assistant and the form was signed by both staff members to demonstrate their agreement of progress.

We saw there were no annual appraisals recorded on the supervision matrix. However staff reported that past appraisals (during the operation of the service by the prior provider) were useful to review their performance and said they could request additional training which was generally well-supported if relevant to their work.

We checked information about people's eating and drinking. Although there was no evidence of any monitoring of nutritional status, we were told that this would be managed by the district nurse in most cases. However care staff did assist with meal preparation if required. The information about this was not always recorded in the care plans, but was documented in the daily visit notes.

Staff told us that they worked closely with other health care professionals such as district nurses, GPs and emergency services as needed as well as other professionals within the provider's own service, such as occupational therapists, physiotherapists, specialist support such as dementia advisors and other teams. This ensured people could regain their independence as soon as possible. Again, some evidence of these contacts was seen in people's daily notes or on the computer system but it was not clear how the healthcare team visits were meant to be documented as there was no consistent system for recording.

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible,

people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA.

There was very good evidence of consent to care and support in care records we viewed. We found there were signed consent forms in the care plan kept at people's home's which indicated an agreement to care arrangements outlined in the care plan. This was signed by people in most cases; there was a 'tick box' on the form to indicate that a person was able to sign, but this was usually left blank. In one case, we the consent form was signed by a relative, but the document did not indicate who this was. We saw the consent forms were dated and also signed by the care coordinator. We found there were also signed consent to the terms of the contract that indicated the duration of the contract and a requirement to provide liquid soap, refrain from smoking and exclude pets during the home visits if required.

We found there was a section in people's care plan documentation to record the existence of a 'do not attempt resuscitation" (DNACPR) decision form, any other advance decision, living will and arrangements such as a power or attorney. This information was also seen in electronic records. Staff explained that they always sought consent before offering to assist with personal care or other daily support.

Good

Is the service caring?

Our findings

People we spoke with felt that care received from staff who provided support were kind. People told us, "They're very kind, caring and polite. They ask me things in a very caring way", "They were very sympathetic. I felt low and they were very encouraging. I can't fault them at all", "They made me feel very comfortable. They were chatty and we shared jokes" and "Yes they were very good, nine out of 10. They were never rude and they always asked for my permission."

People were encouraged by staff to participate in their care and regain their independence. When we asked, people told us, "Yes, I guess so; we're in a routine and just get on and do it!", "Very much so (involved). They would say, 'show me how you do this and that" and "I didn't believe that such a service would be like this…."

Rehabilitation care assistants said that people who used the service were always encouraged to achieve independence as far as possible. We saw there was a section in the care plans for goals and expectations, however there was no specific detail recorded beyond "regaining independence". At the scheduled end of a care package, people would become independent, require an extension of the care package, commence a contact with a domiciliary care provider or move into a residential care location. The service kept records and analysed people's care pathways to determine whether the care provided achieved the expectations of recovering independence. We saw that for the majority of people, at the end of the care package they were able to regain their independence and remain within their own home without additional support. This showed the service was successful in promoting people's independence and encouraged them to regain their functional abilities.

The service manager explained people's privacy and dignity was always respected by workers. Staff were instructed to ensure privacy during personal care by knocking on the door to announce their arrival and seek consent to enter. Staff also closed doors and curtains during intimate personal care. People's preferred names were recorded in their care documents. We saw staff received training on ensuring people's privacy and the provision of care or support in a dignified way. Staff we spoke with also described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains and ensuring that other family members were not present unless requested by the person receiving care.

People's confidential personal information was always securely protected. Mobile phone technology was used to record calls. Paper-based records were used to record information about care provided. Limited information was stored within people's homes. When documents were no longer required in people's homes, they were scanned into a computer system at the office, and destroyed. Information pertaining to staff and other confidential management information was locked away or protected on computers by passwords. Only relevant staff had access to this information. Staff who provided support to people and staff based in the office did not disclose confidential information without verification or people's consent.

At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislation.

Good

Is the service responsive?

Our findings

People explained that the care they received was personalised to their needs. One person said, "I [sustained a fracture] and I really did need the service then. [Now], I feel that I don't." Another person stated, "Yes I did feel [included in] things. I was scared to be left alone in the shower [and the staff] came to give me extra support to give me confidence by walking out of the shower with me." A further person told us that staff had adjusted their care during the duration of the package. They said, "They did indeed. They asked me lots of questions." Further comments included, "The person in charge (staff) came to see me and told me what would be happening. She (staff) went through the care plan involving me in it. The aim was to get me walking after four weeks" and "I have...cancer and they are coming next week to [commence preparations for] palliative care." People's feedback indicated the service was responsive to their individual needs.

As the service was an intermediate type of care, reviews of care were not routinely scheduled. However, as changes in people's requirements or independence occurred, the frequency of care visits was altered to reflect the needs. We saw evidence of people's care packages reviewed by the care coordinators. These were completed either as a home visit or a telephone review with the person and their relatives. We saw each person had a separate file for reviews with the multidisciplinary team (which included occupational therapists and physiotherapists). We were told that there was a weekly multidisciplinary team meeting for each person but some of the forms to record this review were blank, and it was not clear how these reviews worked in conjunction with other records within the care plan.

Care information held in computer records was mainly accessed by office-base staff. Care staff told us they had access to some details on the computerised records and that they received briefing information before their first visit to a person, although this was a summary of key information and the tasks that were required. Some care staff used their work smartphones to relay daily updates on service users to be recorded on the computer system while others recorded daily progress on the handwritten observation sheets and only sent emails or updates if there were specific issues or requests.

On some occasions, people were reviewed on a daily basis if they were considered to be at risk or their health was deteriorating and daily updates were provided by care staff as case notes on the computerised records in the office . It was not always possible to tell whether this was accurately reflected in the daily observation notes as the systems were not linked. However, there was evidence of response to change in needs or health status documented in the electronic system.

We saw each person who commenced a package of care was issued with a "service user guide" which was clear and comprehensive with information on funding, duration of service and the support provided along with relevant contacts within the organisation. There was a separate leaflet provided, covering the complaints procedure and this was appropriate with timelines and further contact points if complaint resolution was not possible. We reviewed the "complaints and compliments" file. We noted there were numerous "thank you" cards and e-mails from people and their families. We saw four complaints were documented although three of these were not relevant to the person's care, as they covered other issues such as funding (which is not regulated by us). The remaining complaint was well-documented with

information on the investigation conducted, action taken and resolution. This information was also recorded in the person's computer record of care.

We found there were no satisfaction surveys completed and there was no documented evidence of structured feedback from people on the service, beyond the compliments received.

We recommend that the service reviews methods of gaining formal feedback from people, relatives and community stakeholders.

People we spoke with told us they were aware of how to make a complaint, but that they had no concerns about the service. Comments included, "No complaints, I think it is a wonderful service", "I had no concerns...I joked with them" and "I would've got through to management (if there was a complaint)." One person explained to us how their concern was professionally managed. They said, "Yes, it was handled very quickly and efficiently. It was good communication and good community care."

Requires Improvement

Is the service well-led?

Our findings

The procedures for accidents and incidents reporting and review required improvement. The service found it difficult to provide us with an adequate record of the number of accidents and incidents, although some were sent as an example after our site visit. As there were multiple ways of reporting accidents and incidents, not all of them were recorded in a robust method. The change of provider in earlier 2017 meant that the current provider's method of recording incidents was not fully implemented at the time of our inspection. We found staff were aware of the need to report the event of an accident or incident and described the form that they completed to document the incident. However, some said that this could be completed electronically while others completed a paper-based form so it was unclear how these different methods were collated.

We found the service conducted regular observational spot checks on the care provided by the rehabilitation care assistants and we saw there was evidence of this in staff files. There was an observational checklist used to record different aspects of service delivery by the staff members which included appearance or uniform, punctuality, relationship with the person who used the service, respect for privacy and dignity, personal care delivery, use of infection control techniques, food hygiene, moving and handling. Although we were told that observational spot checks were conducted for all staff every three months, this was not reflected in the service's log of checks. For example, we saw four rehabilitation care assistants had received spot checks since registration of the provider. This was an insufficient number of checks to determine the ongoing safety of care and quality of the service.

The interim quality lead was new in their post and had visited the service once since their appointment. We reviewed a record they were requested to complete on a complex instance of care for a person. We saw this was comprehensive and covered areas to ensure the wellbeing of the person. Key findings were clearly presented, and actions for the service, staff and management were detailed. We also saw that care coordinators completed a care audit within the first 48 hours of a person's care package commencing.

Further types of checks and audits to ensure that there was good governance of the service were not in place at the time of our inspection, although the provider had sufficient time to implement them between their registration and prior to our inspection. We spoke with the interim quality lead and the service manager about the planned implementation of a standardised system of tools to monitor the quality and safety of the service.

We heard there would be a manager's 'toolkit' available, which included a suite of standardised templates such as meeting agendas, minutes, and audits. In addition, we were told the provider would implement weekly reporting of key events to the quality team via the "safety net" system. This was a computer-based weekly submission of safety and quality measures which would provide oversight of the service's level of function and areas for improvement. Indicators would include information such as safeguarding events, accidents and incidents, missed and late care visits, medicines errors and serious injuries.

The service manager and assistant team manager were clear about their roles in the service. When we

asked, they were able to clearly state their role within the organisation, what they were responsible for, who they were accountable to and what action they took or would take if certain events occurred. We noted a collaborative working relationship between the management team. The service manager told us they would "lead by example" and staff we spoke with confirmed that the manager demonstrated this since commencement in their role. The service manager described they were well-supported by their line manager and that there was ongoing organisational restructure of the provider. The service manager described their rapport building with staff from HR, quality and health and safety. They explained that this was necessary in order to ensure the provision of a good service.

The service manager had recently begun to participate in the relevant meetings at provider-level. These were with other registered managers from other services the provider operated, including care homes. The meetings provided the service manager with the opportunity for peer support and sharing effective ways of working and new ideas. We saw the service manager attended the care governance meeting in August, September and October 2017. The meeting minutes showed topics discussed included staff training, regulation, "what's going well", "what requires improvement", service risks, recruitment and retention of staff.

The management team had created a continuous improvement plan leading up to our inspection. This included a list of actions, responsible staff and due dates for areas which required change or review. We saw the actions were listed under the key questions; safe, effective, caring, responsive well-led. Examples of actions included the implementation of a staff 'data champion' and to ensure that all agency worker profile sheets were on file. We saw that the 'data champion' was in place. This was a staff member whose role was to check that all relevant paperwork was stored, and computers were logged off in the office at the end of each day. The purpose was to ensure that confidential information about people who used the service was not left available to other staff who worked within the office. A checklist was used each day as an aide memoire, and this was dated, signed and stored as evidence. This was an innovative idea to ensure that records or access to them was secure, and protected people's privacy.

There was a positive workplace culture at the service. All of the members of staff we interviewed were extremely positive and enthusiastic about working at the service and most had been in post for several years. They commented that there was very good team work and an open and supportive culture. One staff member told us, "The great thing about the team is that we're well-supported. We can always phone duty (officer) if we're running late and they'll adjust the rota." Another staff member told us, "Everyone is approachable. It's a lovely team and we all help each other out." A further staff member commented, "They're very supportive here. You can put yourself forward for additional training, provided it's relevant, and your manager approves it."

All of the staff we spoke with commented that the change of provider was an anxious time, but that this was smooth transition for them. They felt that the current service manager and assistant team manager were always available and approachable. All of the staff we interviewed explained they would not hesitate to raise concerns or queries if necessary.

Staff reported that the service held regular meetings in the office at which learning and experiences could be shared, and any concerns or issues about people's progress discussed. We saw evidence of monthly meetings was well-documented. In addition there were 'bite-sized' meetings for staff to which external speakers were invited to provide useful insights and advice on various relevant aspects of care and support, including fire safety, continence care, and use of thickening fluids for nutritional support.

Services are required to comply with the duty of candour regulation. The intention of this regulation is to

ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and providing an apology (including in writing).

The service had an appropriate duty of candour policy in place which gave clear and specific instructions for management to follow when the duty of candour requirement was triggered by safety incidents. When we asked the service manager, there were no notifiable safety incidents which triggered the duty of candour requirement. The service manager's knowledge of the duty of candour principles was limited, and we recommended they increase their understanding of the concept and associated processes. They were receptive of our feedback.

People provided positive feedback about the management of the service. Comments we received included, "I've had queries and they're responsive", "Yes, they have definitely listened", "I can't think of anything they could improve. I miss them!", "It's very needed and it's a very reassuring service. It's helpful to get you back to where you want to be", "Yes, (the service) seemed to be (well-run)", "They were all really good", "The management is good" and "I don't think there's anything they could do to improve. I only have high praise."