Southern Housing Group Limited

Southern Housing Group DCA

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

This inspection took place between the 5 & 10 January 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we need to be sure that people would be available.

Southern Housing Group DCA provides personal care and support to people living in their own homes. At the time of the inspection the agency was providing a personal care service to 50 people with a variety of care needs, including people living with physical care needs, learning disabilities, mental health needs and memory loss.

The agency had a registered manager. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

People and their families told us they felt safe and trusted the staff who supported them. Staff understood their safeguarding responsibilities and knew how to prevent, identify and report abuse. Risks relating to the health and support needs of the people and the environment in which they lived were assessed and managed effectively.

Safe recruitment practices were followed and appropriate checks were undertaken, which helped make sure only suitable staff were employed to care for people in their own homes. There were sufficient numbers of care staff to maintain the schedule of visits.

Staff were knowledgeable and received appropriate training to support people. They completed an induction programme and were appropriately supported in their work by supervisors and managers. Medicines were given safely by staff who were suitably trained.

Staff knew the people they provided care to well and understood their physical and social needs. Staff were able to describe how to meet people's needs effectively. Staff referred people to healthcare professionals when required.

Staff, and the registered manager, knew how the Mental Capacity Act 2005 affected their work. They always asked for consent from people before providing care.

People told us they were cared for with kindness and compassion. People received personalised care and support that met their individual needs. Care plans provided comprehensive information to enable staff to provide care in a consistent way. People and their families told us they felt the service was well-led. There was a clear management structure in place and staff understood the role each person played within this structure. Staff felt well supported by the management team. Staff were motivated and enjoyed working at

the service.

The provider sought and acted on feedback from people. There was a suitable complaints policy in place and people knew how to complain.

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 suitable numbers of staff in place to meet people's needs.
People were supported to take their medicines as prescribed.

Staff were knowledgeable about their safeguarding responsibilities.

Potential risks to people were assessed and managed appropriately.

The service had plans in place to sustain people's care visits in the event of emergencies or severe weather.

Is the service effective?

Good

The service was effective.

Systems were in place to ensure staff received training, support and supervision.

Staff understood people's needs and records showed people received appropriate care, food and drinks.

Staff had an understanding of consent and how this affected the care they provided. People said staff always obtained their consent before providing care.

Staff knew people's health needs and described how to meet them effectively.

Is the service caring?

Good

The service was caring.

People were cared for with kindness and compassion.

People felt involved in their care and they were encouraged to be as independent as they could be.

Staff respected people's privacy and dignity.

Staff communicated with people in a caring and respectful manner.

Is the service responsive?

Good

The service was responsive.

People received individualised care that met their needs. Their choices and preferences were respected and met.

Staff responded to people's changing needs.

People felt confident that concerns and complaints would be acted on promptly.

Is the service well-led?

Good

The service was well-led.

People and staff praised the management of the service. Staff were motivated and encouraged to identify improvements.

There was a suitable quality assurance process in place to assess, monitor and improve the service.

There was an open and transparent culture. CQC were notified of all significant events.

Southern Housing Group DCA

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 5 January 2017 and was followed up with telephone interviews to people who use the service and visits to people in their own homes on the 10 January 2017. The inspection and subsequent home visits were announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we need to be sure that someone would be available in the office and consent needed to be gained from the people who were visited in their homes.

The inspection was carried out by one inspector and an expert by experience who had experience of caring for older people, people who have physical impairments and people who use services. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of service.

Before the inspection the provider completed 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. We reviewed previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 12 people who used the service and two relatives, by telephone. We visited and spoke with four people in their own homes. We spoke with the registered manager, the manager of Southern Housing Group's extra care facility (Sheltered accommodation facility that supports people to live independently, while receiving the additional care and support they need), the care coordinator, three

senior care workers, five care workers and a social care professional. We looked at care records that were kept at the agency's office for six people and four care files that were kept in people's own homes. We also looked at records relating to the management of the service, recruitment, training, and systems for monitoring the quality of the service.

Southern Housing Group DCA was last inspected in December 2013, when we did not identify any concerns.

Good

Is the service safe?

Our findings

People and their relatives told us they felt safe and trusted the staff from Southern Housing Group DCA who supported them in their homes. One person told us, "I usually have regular carers but there is a new one sometimes, I do feel safe with them". A relative said "I feel [my loved one] is very safe with them [staff]".

People benefited from a safe service where staff understood their safeguarding responsibilities. A safeguarding policy was in place and staff were required to complete safeguarding training as part of their induction. This training was refreshed yearly. Care staff were knowledgeable in recognising signs of potential abuse and understood the relevant reporting procedures. One staff member said, "I would contact the office staff or manager if I suspected abuse". Another staff member told us, "I would complete the safeguarding form and report my concerns to the manager or go directly to the local safeguarding team if necessary". The registered manager knew how to use safeguarding procedures; they had reported concerns and taken appropriate action when required.

Staff occasionally handled people's money when they bought shopping for them or were required to collect money on their behalf. A suitable procedure was in place for this, to protect people from the risk of financial abuse, which included recording purchases and keeping receipts. We saw that staff were at times offered gifts from the people they cared for. Staff demonstrated an understanding of the provider's gift policy and this was followed accordingly. For example, staff reported offers of gifts to the registered manager and gifts were returned or kept depending on there value.

Robust recruitment procedures were in place which ensured staff were suitable to work with vulnerable people. One care staff member told us, "I was unable to start work until my police check had come back". Staff files included application forms and records of interview. They showed that all appropriate checks, such as references, work history and Disclosure and Barring Service (DBS) checks had been completed. DBS checks identify if prospective staff had a criminal record or were barred from working with children or vulnerable people.

There were sufficient numbers of staff available to keep people safe. Staffing levels were determined by the number of people using the service and their care needs. The registered manager told us new care packages were only accepted in certain locations on the Isle of Wight and then only if sufficient staff were available to support the person. None of the sixteen people we spoke with reported that any of their care calls had been missed. One person said "I don't think they [care staff] have ever missed a call". People told us that care staff usually arrived at the time they were expected and their comments included; "They do turn up on time and I know who is coming", "They come when they can, you can't always be on time with the traffic" and "They are on time, well you can't help the traffic but they aren't more than 10 minutes astray".

The registered manager told us that, due to recent staff sickness, staffing levels were currently being risk assessed and reviewed fortnightly to ensure that staffing levels were safe. Following a recently completed risk assessment and staff audit, the provider had recruited two additional members of staff. Staff absence was covered by other staff working additional hours or by one of the senior care workers who were usually

office based. This provided resilience to help make sure calls were not missed.

Staff and people told us the time allowed for each visit was usually sufficient to complete all of the care and support required and people said that staff always stayed the allotted time. Each person had a scanning code on the front of their care plan which staff were required to activate from their mobile phones when arriving and leaving each care call. This was reviewed frequently throughout the day by the care coordinator in the agency's office to ensure that calls were being completed as planned to keep people safe.

There were safe medicine administration systems in place and people told us they received their medication safely and as prescribed. People's comments included, "They help me do my medicines, they do that alright", "I have one of those boxes for my medication and they [staff] help with that" and "They put out my medicines under my supervision. The pills are so small they are hard to manage". During a home visit a member of staff was observed administering medicine to a person who was unable to do this themselves. Thorough checks were completed by the staff member to ensure that the medicine was being given as prescribed. Medicines within people's homes were stored safety.

Where people were supported to take their medicine, medicines administration records (MAR) were kept in their homes. The MAR chart provides a record of which medicines are prescribed to a person and when they were given. Staff administering medicine were required to initial the MAR chart to confirm the person had received their medicine, which they had done, and no gaps on these charts were identified.

Staff received medicine training during their induction, both face to face and through distance learning. After this training, the registered manager or senior care staff supervised and observed the staff member and completed a 'Staff medicines assessment', to ensure staff competency and further training was provided if necessary. Staff's competency to safety administer medicines was regularly reviewed by the registered manager or senior care staff during six monthly spot checks and monthly MAR chart audits. Safe systems were in place and followed by care staff to support people who required oxygen or prescribed topical creams. Care plans included specific information as to the level of support people required with their medicines and who was responsible for collecting prescriptions.

Risks to people had been individually assessed and risk assessments were in place to minimise these risks. These gave staff clear guidance about how to reduce risks to people and themselves. For example, there was a risk assessment in place for a person who was at high risk of skin breakdown on their legs. This risk assessment stated, 'Encourage [person] to sleep in their bed and keep their legs elevated'. Another person had a risk assessment in place due to their level of anxiety; this stated, 'Don't let [person] become too worked up, if mood is elevating just be quiet and give them time and space'. People had risk assessments in place in relation to; medicines, moving and handling, use of equipment, self-neglect, pressure injuries, skin conditions, nutrition and home safety. Staff were knowledgeable about people's individual risks and the steps required to keep people safe. One staff member said "[Person] is at high risk of developing pressure sores so during each visit I will encourage them to have a little walk around".

Home and environmental risk assessments had been completed by the registered manager and senior staff to promote the safety of both the staff and people. As well as considering the immediate living environment of the person, (including lighting, the condition of property, electrical items and security), risk assessments had been completed in relation to the safety of the location. For example, if lighting was poor or the home was in a rural area. In one case, a person needed improvements made to their property to allow safer access to washing facilities. Staff worked closely with the person, the local authority and healthcare professionals to ensure the person could wash safety.

A lone worker system was in place and staff was issued with a lone worker device and mobile phone to allow them to summon help in an emergency to help keep them safe. This system would alert the senior or registered manager if a member of the care staff had not logged out of the system following a visit. The manager of the extra care facility said that the risks to staff working alone were assessed and where this indicated a higher risk, action was taken. This could include providing two staff to attend calls and they gave an example of where this had occurred. All risk assessments were reviewed annually or more frequently if needed.

The service had a business continuity plan in place in case of emergencies. This covered eventualities that could affect the running of the service such as fire, flooding and adverse weather conditions. It included procedures to follow and emergency contact details for key staff. For example, in severe weather staff may be relocated to areas nearer their home which could allow them to walk, if necessary, to the most vulnerable people. People had been risk assessed to identify those who would definitely still need a home visit, such as those living on their own, and other people who could be supported by phone calls if staff were unable to get to them. This would mean that in the event of severe weather people and staff would not be placed at unnecessary risk.

Good

Is the service effective?

Our findings

Of the 31 people who had responded to the providers 'Customer survey' 30 said they were happy with the care they received. People told us they were happy with the way their care needs were met. People's comments included, "I get lots of support from staff, I couldn't manage without them" and "They [staff] do what I need them to do". A relative said of the staff, "They are very polite and deal with (loved one) very well".

People and their relatives told us the staff were effective and they were confident in the staff's abilities to meet their needs. People told us, "They seem very well trained", "They are 'top class', I can't fault them", "They [staff] seem to know what they are doing", "Most of the carers are very good" and "I sometimes have to tell the younger carers what to do, I'm more confident with the older ones".

Staff had the skills and knowledge to carry out their roles and responsibilities effectively. The provider had arrangements in place to ensure staff received an effective induction to enable them meet the needs of the people they were supporting. Staff told us that when they started working for Southern Housing Group they received training, which included both face to face and e-learning. They also worked alongside experienced staff before they were permitted to work unsupervised. New staff received mandatory training which followed the principles of the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life.

Care staff confirmed that they had access to further training, on going updates and development opportunities. Training staff had received included; health and safety, first aid, food hygiene, moving and handling and infection control. Staff understood the training they had received and how to apply it. For example, they explained how they would support a person to mobilise, manage medicines, effectively communicate with people and support people when if they became anxious. A staff member said, "The dementia training was probably the best training I've had, it was really engaging. It really increased my knowledge about dementia and changed the way I look after people". Another staff member told us, "We are always being offered training".

Some staff had completed specific training to better care for people with additional needs; for example, staff had received hearing impairment training which allowed them to communicate more effectively with people whose hearing was impaired and epilepsy training to support people who experienced seizures.

The registered manager had a system to record the training that staff had completed and to identify when training needed to be repeated. On reviewing these training records we saw that some areas of training were slightly out of date. The registered manager was aware of this and explained that this was due to limited space availability and confirmed that staff had been booked on the next available training in the area of need.

People's health and personal care needs were met effectively by staff because they knew people well. For example, one person had become rapidly unwell, which was picked up quickly by a staff member due to a

change in the person's colour and behaviours. This allowed immediate first aid to be provided. Additionally, one person who sometimes had needs in relation to their emotional wellbeing told us, "When they [staff] see me going downhill, they encourage me to get help; they often know before I do that I am not well".

Staff were supported in their role. Supervisions (one to one meetings) were with the registered manager or senior care workers. Staff told us they received supervisions and additional one to one support regularly which enabled them to discuss any training needs or concerns they had. One member of staff told us, "When I first started, I had supervision every six weeks; I now have it about every six months but can talk to the manager or senior care staff whenever I need to". This was confirmed by another member of staff who said, "I think I get official supervision every six months, but I can ask for extras if I need it and we do get one to one time with the manager". Staff received six monthly spot checks which were completed by the registered manager or a senior care worker to allow them to observe the standard and quality of care being given. Where necessary, actions for improvement were identified and followed up. Staff also received Performance Development Reviews (PDRs) with the registered manager to review staff's skill levels and behaviours and set them performance targets.

People said they were always asked for their consent before care was provided. One person said, "They [staff] always ask me before they do something". Another person told us, "They never just come in; they always knock and ask permission first". During home visits we saw staff gain verbal consent from people before accessing areas of their home or completing tasks. One staff member said "I always ask first and tell them what I'm doing". People's care plans included consent forms which had been signed by the person or their legal representative. Signed consent forms were in place in relation to; care and treatment, medication management and photos.

People's ability to make decisions was assessed in line with the Mental Capacity Act, 2005 (MCA). The 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 decisions made on their behalf must be in their best interests and as least restrictive as possible. Staff were aware of the MCA and had an understanding of how this affected the care they provided.

Proper procedures had been followed for when people were not able to make decisions about their care or support to ensure decisions made were in people's best interest. Staff described the process to follow if they were concerned a person was making decisions that were unsafe. Staff were aware people were able to change their minds about care and had the right to refuse care at any point.

Staff knew people's health needs and described how to meet them effectively. Where people required health care this was arranged in a timely manner. Where a person's health had changed, staff worked with other professionals to respond to people's changing needs. One person's care plan instructed staff to monitor the person's skin integrity and signs of skin breakdown on their legs as they were prone to ulcers. Leg monitoring charts and body maps were held in the person's care plan which were completed appropriately and action had been taken when problems had occurred. Another person required oxygen and staff understood when and how this was to be used. This person's care plan contained an oxygen checklist which prompted staff to check the air flow and condition of the oxygen tubing. Instances where staff identified issues were followed up by contacting the person's GP, district nurse team or other health or social care professionals. A social care professional told us, "They [care staff] are never afraid to ring for advice or ideas on how best to support the people they are working with". People were also supported to access additional services where required, including opticians, chiropodists and dentists.

None of the people using the service required assistance to eat their meals. Care staff involved in the preparation of food had completed appropriate training. Where care staff were responsible for preparing meals, they encouraged people to maintain a diet in line with their needs and their preferences. During one home visit a member of staff was preparing breakfast for a person and choice was offered. One person told us, "They [staff] make me a meal, just what I want or what's in the fridge; that's OK too". Another person told us, "The carers will always ask what I want to eat". Where people were at risk of weight loss, or unwell, we saw food and fluid charts in place which monitored their intake. A staff member said, "If I was concerned about a person's intake I would check their care log and food and fluid chart and report my concerns to the manager. I would also offer different food choices".

Good

Is the service caring?

Our findings

People and relatives told us that staff treated them in a caring and kind way. Comments from people about the staff included: "The carers are very good, lovely in fact", "They are really nice to me, they interact with my large family as well and are very nice to them", "It's very good, the girls are marvellous to me" and "I have a laugh with them [staff], they have a good sense of humour, perfect". A family member said, "They are so very good with [my loved one]". Care staff told us, "I love my job and love the people" and "I will always treat people how I would want to be treated".

The service had received written thanks from relatives and people which praised the care that had been received. One written compliment from a person said, 'Thank you for helping me get my life back together'. Another, from a relative, read, 'Nothing really fazed any of the team. They acted professionally and impartially with their main focus being on [my loved one]'.

Staff understood the importance of supporting people to remain independent. A staff member told us they, "Wanted to make a difference to people and help them remain as independent as possible". A social care professional said, "Staff always try to encourage people to be included in their local community, enabling people to become more independent and less isolated". People's care plans detailed what people could do for themselves and how staff could promote their independence. For example, one care plan said, '[The person] only needs support with putting their t-shirt over their head and underwear and trousers halfway up as they can do the rest'. Another care plan stated, 'Give [the person] time and do not rush them'. One staff member said "I would promote someone's independence by offering support but also encouraging them to do things for themselves. Just because they need help to wash doesn't mean they can't do anything at all". Another member of staff told us, "I never assume that they can't do things themselves". One person said "I like to be independent and the carers encourage and respect that".

People felt they were treated with dignity and respect. People and relatives described the care staff as "polite" and "respectful". A comment viewed from a customer survey sent by the provider to the people who use the service stated, 'Staff are kind and treat me with respect, I don't think you could improve at all'. Care staff understood the importance of maintaining people's privacy and dignity when providing them with personal care. They described how they would close curtains or doors and ensure people were covered when having a wash. A staff member said, "I keep people covered up as much as possible".

The registered manager told us that "Southern Housing Group believes that everyone has the right to live their life with privacy, dignity, independence and choice". The service had appointed 'dignity champions' whose role was to uphold and promote dignity in care. Staff respected people's right to decline support. One care worker said "If a person declined to have support with their personal care I would encourage them and explain the benefits, but would respect their choice".

During home visits we observed staff communicating with people in a caring manner. People's communication needs were considered and care plans contained detailed information on how best to communicate with people. Support had been provided from a local hearing loss organisation to advise staff

on how best to communicate with people with hearing impairments and recent dementia training had provided information on how best to communicate with people who had a cognitive impairment. A staff member told us how they communicated with a person when English was not their first language. They said, "We [staff] have to speak slowly and clearly, be very calm and clear and look at body language".

Staff were confident to advocate for people when they needed support or felt unable to do this themselves. A relative commented about a time the agency supported their [loved one] to receive additional medical input. A senior member of the care staff confirmed this and added, "When I visited I felt that the person needed some rehabilitation before returning home as I could see that they were not as able as previously, so I passed this information onto the health staff". Another relative told us, "They [staff] came with me to the meeting with the social worker and we got [our loved one] a fortnight in respite, but I couldn't have done it without them".

The registered manager had arranged a Christmas party for the people who received care and many of the care staff had volunteered their time to support at this event and provide transport to those who would otherwise be unable to attend. Additionally, both the registered manager and a senior care worker volunteered at the local dementia café to offer social and emotional support to people and their families both who use the service and those in the local community.

The provider understood the importance of keeping all records secure. All records relating to people were kept securely within the agency's office with access restricted to only staff who should have need for access. Records kept on computer systems and mobile phones were secure and password protected.

Good

Is the service responsive?

Our findings

People received personalised care and support that met their individual needs. When we spoke with staff, they demonstrated a good awareness of people's individual support needs and how each person preferred to receive care and support. During a home visit a staff member clearly demonstrated they knew the person they were caring for well, understood their routine and knew what was important to them. One person said of the staff, "They will always act if I had a problem". Another person told us, "They [staff] will always check that I have everything I need before they leave".

People were assessed before their care started to ensure that their needs could be met appropriately and effectively. This allowed the person the opportunity to discuss any care preferences they had, such as times of calls and gender preferences of staff. Six weeks following the start of the service (or earlier if required) the care was reviewed to ensure that the person's needs were being met and they were happy with the service. If issues or concerns were raised, the care would be adjusted accordingly. There was a system in place for care plans to be reviewed and updated as needs changed or annually. This was confirmed by most people whose comments included; "[Named person] comes from the office sometimes" and "[Named person] comes sometimes and asks you things". Records confirmed this and people had signed their care plans to show they had been involved in the reviews.

People's care plans contained clear guidance for staff about the support people required to manage their health and personal care needs. One care plan provided staff with advice and guidance on how to support a person who often declined care and staff were able to tell us the action they took when this happened. All viewed care plans contained clear information to staff about the care tasks required at each visit and information about people's abilities and personal preferences. This supported care staff to ensure that care could be provided in a person centred way.

Care plans included short profiles of people, a summary of their background, support needs, hobbies, interests, personal histories and things that were important to people. This gave staff a clear understanding of the person and a baseline from which staff could monitor the person's health and wellbeing. For example, one care plan stated a person liked to watch tennis on the television; another highlighted a person's preferences around food choices; a third detailed the name of the person's pet and directed care staff to check that the pet had food and water. Staff told us they found the information within the care plans useful and that it helped them to have a better understanding of the person. During one home visit it was clear that the staff member understood the importance of a pet to the person, by offering to hoover while the pet was upstairs.

Staff recorded the care and support they provided at each visit. Care records demonstrated that care was delivered in line with people's care plans. Staff told us they were always informed about the needs of the people they cared for and could consult care plans which were held in people's homes and the agency's office when required. Staff were kept up to date about any change in people's needs via a secure mobile phone which allowed them to receive group emails from the office staff.

The agency was able to respond to changes in the person's needs, even if these were unpredicted, such as ill health. One staff member told us, "If I needed to stay longer, I would just let the office know". Another member of staff said, "I have had to stay over my call time before as someone was unwell. I just phone the office and they arranged for my next call to be covered". A relative said, "With the holidays and things they have been very flexible with changing things". The service had an 'Out of Hours' service that could respond to people when required. One person told us, "I had to call out of hours at the weekend, I have never had to call them before but they were really helpful".

The registered manager sought feedback from people or their families through reviews and the use of a quality assurance survey questionnaires. The registered manager said "We strive to do these every six months, or at least annually". At the time of the inspection, quality assurance survey questionnaires had just been sent to people and their families so we were unable to view these. However, we saw the results from the previous questionnaire survey, which had been completed in April 2016. The results of the survey, which were predominately positive, had been analysed and assessed. The registered manager said that if the forms identified any issues then they would address the concerns directly. People confirmed that the most recent quality assurance survey questionnaires had been received.

Southern Housing Group had not received any written complaints in the last 12 months. There was a complaints procedure in place and staff knew how to deal with any complaints or concerns according to the service's policy. Each person was provided with information on how to make a complaint prior to the start of their service, both verbally and in writing, and were reminded of how to complain in the service's quarterly newsletter. Everyone we spoke with confirmed they knew how to complain and would do so if the need arose. People and relatives were confident that the registered manager would take their concerns seriously and take appropriate action if required. People's comments included, "No complaints, it's been very good", "I have never complained but I have said if someone isn't any good and they have dealt with it no problem" and "If I had a complaint I would approach the manager, they would take it seriously and take action". The registered manager was able to explain the complaints procedure and actions she would take. This included meeting with the complainant if they wished, fully investigating the concerns and issues, keeping appropriate records and apologising verbally and in writing to the complainant.

Good

Is the service well-led?

Our findings

Most people and their families told us they felt the service was well-led. A person told us, "I would say it was an excellent service, never had a problem". Another person said, "It's well organised and well run". Relatives comments included, "I can't fault them really, they have been so helpful to me and my [loved one]" and "On the whole we are very happy with it". Feedback from the provider's quality assurance survey, completed in April 2016, highlighted that of the 32 people who responded, 28 would recommend the service to family and friends, four people said they may recommend it and three said that they wouldn't recommend the service. A few people told us of occasions when some staff had not made them feel valued however, they also gave examples of when other staff had been excellent. A social care professional were positive about how the service was run and told us, "They [staff] work well together".

There was a clear management structure, which consisted of a registered manager, senior care staff, care staff and support staff. Staff understood the role each person played within this structure. The registered manager was aware of, and kept under review, the day to day culture in the service, including the attitudes and behaviour of the staff. This was done through observations of care provision, one to one meetings, care reviews and staff supervision. One staff member described the registered manager and senior carers as, "Hands on and involved". Another staff member said, "I feel comfortable in my job. I can pick up the phone anytime and the registered manager or senior care staff are always happy to listen. I have confidence in the manager".

The registered manager and senior care staff said they led by example and would not ask the care staff to do something they were not prepared to do themselves. When necessary the management team would also undertake a range of tasks, including providing direct care to people. This was done not only during times of staff shortages or for emergency purposes, but regularly to help ensure they kept up to date with issues that care staff faced during their daily working tasks. Throughout the inspection it was clearly evident that the registered manager and senior care staff knew people and their needs well.

The registered manager kept up to date with best practice through regular training and reading relevant circulars and updates provided by trade and regulatory bodies. They attend regular team leader meetings and specific CQC meetings which are run by the provider, where best practice is shared and general discussions are held about the performance and compliance of the service. The provider has external and internal auditing and feedback mechanisms in place to provide the registered manager with support and development opportunities, this includes inspections of the service by Southern Housing Group's head of care and includes, quality assurance inspections and reviewing feedback from customers, relatives and stakeholders. Additionally, the registered manager receives regular supervision and performance appraisal's from the head of service, is a 'Dignity Champion' for the service and had gained a qualification in dementia care.

Southern Housing Group's vision and values were built around the service's CASI (Care and Supporting Independence) plan. The registered manager told us, "The service aims to provide a person centred approach to care and maintain people's independence and quality of life". Regular management and staff

meetings provided the opportunity for the registered manager to engage with staff and reinforce the service's values and vision. We discussed the service's vision and values with the staff and all demonstrated a clear understanding of these. One staff member said, "It's about them [people]" and a second staff member told us, "We work hard to provide high quality care and support people to remain independent so they can stay at home".

Feedback from staff was sought on a regular basis, through one to one meetings, care staff weekly office days, which allowed staff time in the office to update care files and speak with managers and office staff, regular team meetings and quality assurance questionnaires. Staff were encouraged to make suggestions about improvements that would benefit people. One staff member said, "It's a good company to work for, management are very supportive and will take our comments on board, they value us and our opinions". Written feedback from staff questionnaires was provided in a 'You said, we did' format. This demonstrated that staff issues and concerns were valued and action was taken to improve working standards.

People who used the service were kept up to date about the organisation through written correspondence, an in house weekly update (via email) and a quarterly newsletter. During the summer of 2016, Southern Housing Group DCA held a 'Supported Involvement Day' and people who used the service were invited and supported to attend. This event provided people with the opportunity to meet others in similar situations, receive updates on organisational changes and share feedback about their care.

There was an open and transparent culture within the service. The registered manager was open during the inspection around the recent staffing challenges the service had experienced. We also saw a written apology to people in the quarterly newsletter for any disruption to their care caused by the shortages. A relative said, "They are very good at messaging me if anything was wrong". A person told us, "They [staff] apologised, when there had been confusion over a care call". There was a duty of candour policy in place to help ensure staff acted in an open and transparent way when mistakes were made and staff were aware of this.

There was an appropriate quality assurance process in place to monitor the quality of service being delivered and this aimed to continually improve the service provided. The daily care records and MAR sheets kept in people's homes were returned to the office monthly and these were reviewed by the registered manager or senior care staff in order to pick up any recording errors, missing entries and trends for staff performance and engagement with people. Audits of each aspect of the service, including care planning, medicines and staff training were conducted regularly. These identified changes that needed to be made, which were then actioned promptly.

There were processes in place to enable the registered manager to monitor accidents, adverse incidents or near misses. These helped to identify any themes or trends, allowing timely investigations, potential learning and continual improvements in safety.

Where CQC had been notified of significant events or safeguarding concerns we were satisfied that the registered manager had taken the appropriate action. This meant that the manager was aware of and had complied with the legal obligations attached to her role.