Life Choices Plus Limited

Everyday (North Tyneside)

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?	Requires Improvement

Summary of findings

Overall summary

This was the first inspection of the service since a change in registration in May 2017. At the time of the inspection there were 332 people using the service.

Everyday (North Tyneside) is a domiciliary care agency that provides personal care to people living in their own houses and in specialist housing. It provides a service to older adults, including people living with dementia and younger disabled adults. This service provides care and support to people living in specialist 'extra care' housing. Extra care housing is purpose-built or adapted single household accommodation in a shared site or building. The accommodation is bought or rented, and is the occupant's own home. People's care and housing are provided under separate contractual agreements. The Care Quality Commission does not regulate premises used for extra care housing; this inspection looked at people's personal care and support service.

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

We found there was sufficient staffing capacity and people received a reliable and consistent service. The staff were trained, supervised and had the necessary skills to support people effectively.

The service had established systems to protect people from harm, abuse and risks to their personal safety. Where required, people were provided with appropriate assistance with their medicines and in meeting their health-related and dietary needs.

People were consulted about and consented to their care. The implications of mental capacity law in upholding people's rights were understood and put into practice.

Supportive relationships had been formed between people, their families, the staff and management. People felt they were treated kindly, that staff had a caring approach and were respectful of their privacy and dignity.

People were informed about what they could expect from using the service. Further information, advice and local support services within the organisation were made available to people and their carers. There was good teamwork in co-ordinating and delivering people's care.

Care planning was focused on the individual's needs, preferences and provision of personalised care. The staff teams worked flexibly and were responsive to people's changing needs. Care staff provided companionship and, where possible, supported people to prevent them from being socially isolated.

People were encouraged to express their views about their care experiences and the service they received. Feedback was used to influence improvements and any complaints were taken seriously and responded to.

The service worked openly and inclusively with people, their relatives and staff. There were good leadership and governance arrangements, and aims were set each year to develop the quality of the services provided. We found some issues with quality assurance and have made a recommendation about more robust auditing of records and monitoring of the timings of visits.

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.

Appropriate steps were taken to safeguard people against abuse.

Risks were assessed and managed, including measures to control the risk of infection.

Enough skilled staff were employed to safely meet people's needs.

People received suitable support to take their prescribed medicines.

Lessons were learned from untoward incidents and led to changes in practice.

Is the service effective?

Good

The service was effective.

People were provided with good standards of personal care by staff who were well trained and supported in their roles.

The service assisted people, where required, in meeting their health care and nutritional needs.

Staff worked together, and with other professionals, in co-ordinating people's care.

Systems were in place to ensure people consented to their care.

Is the service caring?

Good

The service was caring.

Staff were kind, caring and supportive of people and their families.

People were encouraged to express their views and make decisions about their care.

Privacy and dignity were respected and people's independence was promoted.

Is the service responsive?

Good

The service was responsive.

Care was tailored to the individual and the ways they preferred to be supported.

People were informed about the complaints procedure and the service responded to any concerns received.

Arrangements could be made to care for people at the end of their lives.

Is the service well-led?

Requires Improvement

The service was not consistently well-led.

More thorough auditing and monitoring are recommended to make sure the management has full oversight of the services being delivered.

The service had an open, empowering culture and worked in partnership with others.

Regulatory requirements were understood and the service was well-managed.

There was a clearly defined governance structure that supported continuous improvement.

Everyday (North Tyneside)

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 was 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.

The inspection took place on 7, 8, 9 and 15 November 2017 and was announced. We gave 48 hours' notice to be sure the management would be in the office and available to assist the inspection. The inspection site visit activity started on 7 November 2017 and ended on 15 November 2017. We visited the office location on 7 and 8 November 2017 to see the manager and office staff and reviewed the service's systems and records. On 9 November 2017 we visited an extra care housing scheme and telephoned people using the service and relatives. On 15 November 2017 we visited two extra care housing schemes. The inspection was carried out by two inspectors and two expert-by-experiences. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, the provider had 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 the PIR and other information we held about the service prior to our inspection. This included the notifications we had received from the provider. Notifications are changes, events or incidents the provider is legally obliged to send us within required timescales. We contacted a local authority commissioner and Healthwatch, the local consumer champion for health and social care services.

The inspection was informed by feedback from questionnaires completed by 12 people using the service, two relatives and 20 staff. During the inspection we telephoned 10 people using the service, three relatives and met and talked with 23 people and two relatives to obtain feedback about their experiences of the service. We spoke with the registered manager, the chief and deputy chief executives, two trustees, the head of corporate support, a human resource advisor, four care at home managers, five team leaders and seven care workers. We examined 20 people's care records and reviewed other records related to the management and quality of the service.

Good

Is the service safe?

Our findings

People using the service felt safe with the staff who supported them. They told us, "They are really nice and haven't given me a reason not to trust them", "Safe and well looked after is the same thing to me, and yes I am", "I trust the staff", "Oh I'm very safe in every way" and "Yes, now I feel safe but I didn't at my last place, which is why I came here." A relative said, "We are so pleased our relative is safe and sound and someone is taking care of them and keeping them safe." Another relative told us, "(Family member) was very safe in every way."

The service provided people with information about their rights to be safeguarded and how to report any abuse. Staff were introduced to the provider's safeguarding and whistleblowing (exposing poor practice) policies and received training during their induction. Safeguarding training was updated every two years and evaluated to check that staff had sound knowledge and understanding of how to recognise, prevent and report abuse. Safeguarding issues were also discussed in supervision and staff meetings to continue to raise awareness.

The staff we talked with, and who completed our questionnaires, knew what to do if they thought anyone was being abused or was at risk of harm. Their comments included, "I'd report it to my line manager" and "If I had any concerns about someone's safety I'd report it straight to the manager." The registered manager understood their safeguarding responsibilities and kept a log of allegations which had been reported. They had taken appropriate action, including raising alerts that did not implicate staff to help protect people from suspected abuse from others. A commissioner confirmed that the service complied with the local authority's safeguarding procedures.

Staff had guidance to follow about adhering to professional boundaries, gifts and the handling of people's money. Any support people needed with their finances was assessed and built into care plans. Transactions by staff, mainly shopping on people's behalf, were recorded, where possible countersigned by the person, and backed by receipts.

Recruitment of staff was ongoing to meet the demand for services. The service now specifically targeted employing staff with care qualifications and offered opportunities for career progression to support staff retention. We saw all necessary pre-employment checks had been undertaken to check the suitability of new staff. Candidates completed an application form, were interviewed, and proof of identification, a criminal record check and two references, including one from the last employer, were obtained. In one instance a character, rather than a professional reference, had been sought as a second reference, although there were other sources of previous, relevant employment. This was discussed with and taken on board by the registered manager and human resource advisor.

There was sufficient staffing capacity and people felt they received a reliable service. They told us, "Carers are usually on time and stay for the time agreed", "If a carer is running late, I get a call" and "A few calls have been late but nothing excessive. Just the usual which I'm guessing is due to traffic. They are always apologetic." Teams of care staff worked into geographical areas and work schedules were planned

electronically. Each of the extra care housing sites had a dedicated staff team providing 24 hour support and rosters were forward planned. A care worker told us the staffing arrangements gave people continuity of support.

Cover for absence was provided by existing or bank staff for continuity and external agencies were not used. There were on-call arrangements outside of office hours and staff confirmed they received a good response if they needed advice or support. A staff member told us, "There's always someone answers the phone in an emergency."

Care records demonstrated that risks to the individual had been assessed. Strategies to reduce risks addressed, for example, mobility, falls, moving and handling, skin integrity, nutrition and risk of choking. Any equipment used, infection control measures and the number of staff required to safely support the person were specified. Environmental risks were taken into account to ensure the person and staff were not adversely affected by potential hazards. On-site supervisions checked that staff referred to risk assessments and used equipment safely. They also checked staff prevented infection through good hand hygiene, use of disposable gloves and correctly disposed of waste products. A staff member told us, "I've had infection control training and we have protective equipment to use if it's needed."

People living in extra care housing told us there was good security and that fire drills were carried out. Personal plans were devised to support tenants in the event of needing to be evacuated from their homes. Emergency planning formed part of each person's care plan, capturing details of who they wanted to be contacted in an emergency. A person in extra care housing commented, "The only rule seems to be that they like you to tell them when you are going out and coming back - a safety thing I suppose." A business contingency plan was in place to manage the service in emergency circumstances.

An electronic log was kept of accidents, untoward incidents, safeguarding allegations and the actions taken in response. These were relayed in health and safety reports to the governing board and analysed for themes. Lessons were learned when things went wrong in the service and were used to make improvements. For example, following some visits to people being missed, the service had implemented improved rostering and ensured staff confirmed they had received their weekly rosters.

The service had policies on data protection, confidentiality and obtained people's consent for sharing their personal information. Care plans were well recorded and gave staff detailed information on how to provide safe and appropriate care. An overview of the care plan was also sent electronically to staff in advance of when they covered visits to people. Clear expectations were set for staff about documenting the times and the care they delivered at each visit. Records were held in the person's home, readily available to the relevant staff, and were kept up to date.

All care staff were trained in the safe handling of medicines and had an assessment of their competency on an annual basis. The risks involved in supporting people with their medicines had been assessed and care planned. Lists of current prescribed medicines and body maps for applying topical creams/ointments were maintained. People told us they received their medicines on time. One person said, "I take my own medicines from the pack, but the carer does check for me." Staff recorded the medicines they had administered to people in a section of the daily diary. We noted some anomalies in the records and contradictory details about the support people required, which had not been properly identified by internal audits. We have made a recommendation about more frequent and robust auditing as part of the provider's quality assurance process.

Good

Is the service effective?

Our findings

People and their relatives felt the staff were appropriately skilled in providing their care and support. They told us, "I've never had any reason to question the staff training and to be honest it has definitely improved over the last two years", "They do everything very well; they are very good"; "Yes, they are well trained" and "They know their duties and jobs." A relative commented that staff were, "Very well trained and did things beyond the call of duty", when their family member had needed 24 hour care.

New staff were able to undertake the Care Certificate, a standardised training approach in health and social care. As most new care staff employed had already achieved care qualifications, they were provided with a fast track induction with updated mandatory training and an induction to the organisation. Dependent upon experience, provision was made for new staff to have up to 25 hours of shadowing other staff before working alone. All staff were issued with a handbook from the United Kingdom Homecare Association, a member-led professional association, as a reference guide to practice standards.

The service had its' own training suite and training manager who organised and delivered a range of courses. Training in safe working practices was refreshed every one to three years and courses specific to the diverse needs of people using the service were provided. Staff told us, "Training is always going on", "I've done training such as safeguarding, health and safety, and moving and handling", "Staff get in-house training and other training is also sourced", "I've done training about dementia and mental capacity", "You can do extra, for example, alcohol awareness and aspects of dementia care", "Developmental training is provided. A person has bi-polar and staff have had some training about this" and "There's a good dementia course where you see it through the eyes of the person with dementia." All training was monitored by the managers of each staff team and overseen by the registered manager to ensure it was kept up to date.

There was a delegated system for making sure all staff received supervision and appraisal throughout the year to support their personal development. This included observing care staff carrying out their duties with people, assessing their care practice, competencies and communication. Staff confirmed regular supervision was provided, staff meetings were held and they had good support from their line managers. Comments included, "I do on the job supervisions. For instance, if there was a medication error or a missed call, the staff member would be observed and supervised", "I have regular supervision. I fill in a sheet and we look to see if any extra training is needed", "We have staff meetings regularly, every two months" and "There are opportunities for personal development. I started as a care worker and I'm now a team leader."

Staff felt there was good communication and that they worked well together in providing people's care. They told us, "There's good team work in here, always someone to call upon and we cover for each other", "Communication is very good, we're kept informed" and "We have a handover from one shift to another. Everything is documented in the book and in people's care records if something has happened."

As part of the Age UK North Tyneside charity, the service was able to direct people and their carers to information, advice and other services including three well-being centres run by the organisation. The service was now working in conjunction with specialist dementia nurses, to co-ordinate care and give

support to people living with dementia and their families. The nurses had begun to train managers and team leaders in dementia, delirium and depression and this training was planned to be rolled out to other staff in the future.

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.

We found the service worked within the principles of the MCA and trained staff to understand the implications for their practice. New documentation had been introduced that prompted checking the person's ability to give consent to, and make decisions about their care. This also established if a capacity assessment had been completed, any decisions made in the person's best interests, and whether they were represented by an appointed power of attorney. For example, records showed a person had received advocacy support in making the decision to move into extra care housing. Their care plan recorded they were, 'Able to communicate needs and wishes. Can make own choices with regard to day to day living.' People had signed to agree the contracts for their care service and their care plans.

People confirmed that care was given with their agreement. One person said, "Staff always explain what they are going to do before they do it and ensure I fully understand. We have got used to each other now and are in a routine, so it is only new things that we need to go through." Another person told us, "A few times staff have left early, but they always ask if there is anything else they can do first, they always ask my permission."

Staff were trained in assisting people with their dietary requirements and, where needed, helped with food shopping and preparing meals, snacks and drinks. People's nutritional needs and risks had been assessed and were addressed in care plans. These included special diets, prescribed supplements, advice from dietitians and any support with eating and drinking. For example, one person's plan stated, 'I suffered from choking episodes in the past and need to be supervised at mealtimes'. Food and fluid intake was also monitored if the need arose. People living in extra care housing had the flexibility of taking a choice of meals provided by on-site catering facilities.

Information had been gathered from people about their medical history, current health conditions and how these impacted on their care. Advice given by healthcare professionals was recorded, ensuring staff had guidance to follow. People said that staff checked on and were vigilant towards their health and welfare. They told us, "The staff are always popping in to see if I'm okay" and "They know their jobs. They put my (support) stockings on as I have bad legs. It's the staff that tells me when I get an infection." A relative commented, "(Family member's) health was looked after." Other people recounted times when staff had encouraged them to contact their GP, other healthcare services, or had done so directly on their behalf. Arrangements were made to support people in advance of attending appointments and, if possible, to accommodate staff escorting people to hospital.

Good

Is the service caring?

Our findings

People gave positive feedback about the support they received and the caring nature of the staff. They told us, "I'm treated very well", "It really is a 'home from home'", "We've got good relationships", "I'm well cared for", "They do everything I need, what more can I ask for?", "The staff are kind", "They are good and are very understanding. I wouldn't like to be anywhere else, I'm happy here", "Sometimes they carry out tasks they are not obliged to. They aren't asked to, but always want to help me", "It's a great atmosphere, everyone gets along" and "The carers can't be faulted." Most of the people who completed our questionnaires indicated they felt that the staff were caring and kind. A person had commented at their care review that, 'All care workers are smashing. I like everything the way it is'.

Relatives were appreciative of the care given to their family members. Their comments included, "Its exceptional care and no one will have any problems", "I'm generally happy with the service" and "My (relative) was washed, hand fed and got plenty of drinks. I can't fault the excellent care. We would come in every day at different times and the care was excellent."

The service's recruitment process was values-based with an emphasis on selecting new staff who displayed the right caring qualities. Induction was tailored to the NHS 'six C's' of care, compassion, competence, communication, courage and commitment. Supervisory staff checked this culture was embedded by observing care staff practice and seeking people's views about their care experiences.

We saw staff were friendly, respectful and addressed people appropriately. The staff we talked with demonstrated caring approaches and told us they were given time in which to provide individualised care. For instance, a care worker was being afforded time to help a new person settle into the extra care housing environment. We observed a frailer person who needed additional support looked well cared for and comfortable in bed. They told us, "The staff are gentle and take good care of me." Another person described attention to detail, telling us, "They even wind up my watch and put it right for me. I know that this is a little thing in the scheme of things but it means the world to me."

The service aimed to match care staff according to people's preferences and, wherever possible, introduce new staff. A care at home manager said staff would be changed on request, or if there were difficulties with compatibility. People told us they were visited by regular care staff who understood their needs and that they were informed of any changes. A relative said, "We mostly know which carer to expect. Sometimes it has to be a different person, but that's to be expected, as long as I know before they arrive it is fine."

People felt they were supported in ways which promoted their privacy, dignity and independence. They told us, "They are good and shower me with dignity. They are taking me shopping tomorrow. I buy my own food, choose my own clothes", "The carers are themselves dignified and understand the need for privacy and avoiding any awkward moments", "I do as much as I'm able and they do their job really well", "I get a shower at least three times a week. They keep my dignity and help me keep my independence and it now makes getting washed a pleasure instead of a challenge and a chore" and "They try to keep us as independent as possible. Their motto is 'if you can use it use it, otherwise you lose it'." Relatives also commented that staff

helped maintain independence by supporting people and not doing everything for them all the time.

People and their relatives told us the staff and management were supportive and spent time listening and engaging with them. Their comments included, "It's nice to be able to have chats and feel included", "I can have a laugh with them", "If my carer has finished all the jobs, she will sit and have a chat - that is the best bit for me" and "They stop and listen when they are not too busy. If they can help, they will help."

We saw care plans were sensitively recorded and reflected both the emotional and practical support that people needed. For instance, one person's plan reminded staff to be mindful of their low mood due to loneliness. Another person's care plan stated, 'Encourage X to eat meals with other tenants and join in with daily activities. X knows to speak with a member of staff if he is needing help or feeling down.'

People were provided with easy to understand information about the service and made choices and decisions about the care they received. They confirmed they were involved in care planning and reviews of care and some people's views were represented by their families. One person said, "I know about review meetings but to be honest I am at the point where a relative can see to that for me." If necessary, people could be signposted and given details about independent advocacy services.

Good

Is the service responsive?

Our findings

People and their relatives told us they were consulted about and contributed to care planning. Their comments included, "I am always asked my opinion about care. It makes me feel included in what is going to happen" and "All our family are always involved in discussions about the care, which is great because it's all about (relative)." Some people we talked with were happy that the staff knew what care they needed and did not feel they needed to be involved in their care plans or reviews.

The registered manager told us they would not compromise on the time required to provide good standards of care. Shorter visits were only undertaken in circumstances where people needed minimal support, such as prompting to take medication. The service responded to people's changing needs, carrying out reassessments and informing commissioners when support hours needed to be increased.

The service used a computer-based system to plan visits and people were given the option of receiving their rosters. Staff had mobile telephones with an application they used to report when they arrived at and left people's homes. Some problems had been experienced with the functioning of this technology, so alternatives were being trialled. Some people used technical aids which enabled staff to be responsive to their needs and ensure they received timely support. These included door and bed sensors, falls pendants and a 'buddi' clip/wristband that would alert others to the person's location for safety purposes. Staff told us other people with disabilities had adaptations built into their home which they could control to help retain their independence.

In extra care housing, more staffing was able to be adjusted when people needed additional support. A staff member told us, "Care can be flexible at night, for example if someone has just come out of hospital, we have a couple of floating care workers." The staffing capacity also allowed for checks to be made on people's welfare. People confirmed the staff came quickly if they ever needed to summon assistance outside of their usual visit times. They told us, "I've pressed the buzzer a couple of times and staff came straight away" and "They are very good indeed and come as fast as they can."

Care records showed people's needs and any associated risks had been properly assessed and the information used to develop personalised care plans. The care plans addressed all identified needs, the individual's routines and the extent of care and support to be provided at each visit. Outcomes were set, such as ensuring the provision of personal care maintained the person's dignity, hygiene and well-being. 'Walk through' documents were compiled for some people, giving staff very detailed and specific step-by-step guidance on their preferred ways to be supported. There was evidence that care was reviewed and adapted when necessary, for example, when a person had returned from hospital, had reduced mobility and needed hoisting equipment. Daily diary entries were recorded by staff, accounting for the care they had provided at each visit.

People were provided with an informative welcome pack about the service which could be made available in larger print, in audio form, sent by email, or translated into different languages. Each person was also asked about their preferred means of communication with the service and given contact details. People's

individual communication needs were assessed and care planned, taking account of any sensory loss. For instance, one person's care plan advised staff to, 'Ring bell on door as X is profoundly deaf (hearing impaired) and a light flashes in her room. Enter room making sure not to startle her. X can lip read so need to position self in front of her. Speak slowly and clearly. Explain what you are going to do.'

Information had been gathered to inform staff about people's backgrounds and social interests. A minority of people had social support funded as part of their care service to do activities and go into the community. In extra care housing, staff supported people to attend the in-house activities and events which were organised by the tenants and volunteers. The service had recently used funding from the Veterans Association to provide entertainment events. People living in extra care housing described a good atmosphere and ambience. One person said, "It suits my lifestyle and I've made new friends." People at risk of social isolation and their carers were also directed to the organisation's local well-being centres, dementia support groups and 'memory cafes'.

People were given a 'customer how to complain guide' and told us they knew how to make a complaint if they were ever dissatisfied with the service. People and relatives we talked with had no current concerns about the care received. Their comments included, "We know how to complain. It's one of the first things we found out how to do, touch wood we won't have to do it though", "I do know how to complain, but given how good things are I don't think I will need to anytime soon" and "I know the manager would sort it, but I'm happy to say there has been no problems whatsoever." We saw six complaints were logged over the past year, each of which had been appropriately investigated and responded to. Six compliments had also been received, giving thanks and praising staff for the quality of care provided.

The registered manager told us the service at times provided care at the end of people's lives. More time and greater flexibility with staffing was arranged to make sure the person was comfortable and their family was given support. A specialist care plan was implemented and staff usually worked with community nurses. We observed a detailed care plan, though suggested it would be beneficial to capture the person's wishes about their end of life care whilst they were still able. Where applicable, people's instructions not to be resuscitated and emergency health care plans were in place.

We talked with a relative who was very happy with the care their father had received at one of the extra care housing schemes. They told us, "My father loved it here. Everyone is friendly, good care, the manager is approachable and nothing was a problem. We were thrilled with his care. His funeral is tomorrow and we are going to mention the home, carers and manager in his eulogy."

Requires Improvement

Is the service well-led?

Our findings

The registered manager was experienced, qualified and understood their responsibilities and registration requirements. They were supported by the provider, kept close oversight of the service and had regular contact and weekly meetings with the care at home managers. The managers had either achieved or were studying for leadership and management qualifications. They had, along with team leaders, been provided with further internal management training following changes in their respective roles earlier in the year.

There was a clearly structured governance framework with defined roles and accountability. The trustees had an extensive range of professional experience, met bi-monthly and followed a work programme based on the organisation's governance principles. This included considering a variety of reports and updates on performance, impact, health and safety, and the quality of the service. Sub-committees kept different aspects of the service under review, such as resources, risks and compliance with standards. Regular leadership meetings were held between the chief executive, deputy chief executive and heads of service, including the registered manager, which were aligned to the service's aims.

The service worked to a strategy, with the vision of 'A world where everyone enjoys later life' and the mission 'To help people make more of life'. Each year key performance targets were set in order to achieve six aims. These were focused on empowering and engaging with people and staff, to support the voices of older people, and work in partnership with stakeholders to improve services. The strategy was underpinned by the service's ambitions and its' stated values of being optimistic, inclusive, dedicated, enabling, responsive and realistic, which all staff were made aware of.

Staff had been informed of the previous year's strategic highlights, with the positive outcomes and targets met, and the forthcoming priorities for 2017-2018. These included expanding services, ensuring sustainability and exploring further development opportunities. Progress was routinely reported on to the board of trustees and relayed to staff through briefings and meetings. A trustee confirmed to us that the board was kept well appraised of the operation of the service, including any challenges and quality issues.

The service had undertaken a review of policies and procedures. New and revised policies, based on current best practice and legislation, had been introduced. A policy of the month schedule was in place that ensured care and employment related policies were discussed and reinforced with staff of all grades at team meetings. There was a 'duty of candour' policy that the management understood and followed. This duty requires providers to be open, honest and transparent with people about their care and treatment and the actions they must take when things go wrong.

People and relatives told us the service was well managed. Their comments included, "The management are always available and ensure any changes are passed on", "The office staff always answer the phone and deal with questions or queries immediately", "They don't need to improve from where I'm standing", "It's well run" and "I'd make no changes, as I can't fault them in any way." In extra care housing, people confirmed that knew who the managers were and felt they could approach them with any problems they

had.

Staff were equally positive about the support they received from the management. They told us, "It's a good company to work for", "I do feel valued and listened to", "I feel supported and involved. Information is cascaded from the leadership team to us so we know what is going on", "We have a good HR (human resources) team, very supportive", "Management are very approachable and understanding" and "I've worked here for years. It's a good organisation, the best job I've ever had." A care worker told us the senior management were accessible, they would feel able to contact the registered manager directly, and had met the chief executive at functions. We noted the chief executive, deputy chief executive, the registered manager and other heads of service were all involved in the organisational induction for new staff. Appraisals for staff were based on competency and demonstrating they applied the behaviours and values of the service.

Many comments were made by staff about their good relationships with colleagues, teamwork and effective communication. One worker told us how the staff team had been supported and motivated when there was a safeguarding issue affecting their particular service. They said, "There's more stability and morale is now good." At team meetings, staff completed reflection forms looking at what they had done well, could have done better and any challenges they had encountered. These gave management a 'sense check' of morale and enabled staff to highlight any personal development needs and requests for additional support.

Staff were provided with 'core brief' discussion documents and monthly briefings from the chief executive, ensuring they received messages and updates from the senior management. Surveys had been conducted with staff as part of the organisation's assessment by Investors in People, an external quality accreditation scheme. An employee forum was operated to engage with staff and the registered manager told us feedback had led to a number of changes being made. These had included permanent contracts, loyalty awards for long service and a pool of five cars for staff use. Better health campaigns had been run, promoting and educating staff on their physical and mental well-being. An annual 'thank you' party with awards was also held for staff that the trustees and senior management attended.

Feedback was sought from people about their satisfaction with the service. The most recent contact with new customers showed that all would recommend the service to others. New trustees visited the extra care housing schemes to meet people using the service and hear their views. Findings from annual questionnaires, lastly carried out in June 2017, were predominantly positive and numerous comments praising the service had been received. Actions taken forward in response were to improve communication about visits with people by the office staff and minimise changes to care staff. A commissioner told us the local authority did not have any contractual issues with the service. The organisation had performed well at their last quality monitoring visit, though feedback had also highlighted the need for improved communication with people using the service. The registered manager told us these matters were being addressed.

We found that auditing of records to validate the care people received, and financial audits to check safe handling of money, were infrequent and not sufficiently thorough. The audits had been carried out annually and discrepancies we observed in the records, which could potentially impact on people's support, had not been identified. We also noted that although all visits to people were verified as completed each day, more in-depth monitoring was needed. For instance, to check durations and confirm that visits were being conducted within the scheduled times.

We recommend the provider introduces more regular, robust auditing and visit monitoring as part of the quality assurance process.

The registered manager assured us revised audits would be implemented on a monthly basis, to provide closer scrutiny of care and financial records, and be signed off by managers. They were also looking into running reports from the electronic system to further monitor visit timings.