Oxford House Community Care

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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?	Outstanding ☆

Summary of findings

Overall summary

About the service:
Oxford House Community Care is a domiciliary care agency. It provides personal care to people living in their own homes. It provides a service to older adults, people with dementia, people with mental health conditions and people with a physical disability. At the time of our inspection 156 people used the service and there were 70 staff employed. For more details, please see the full report which is on the CQC website at www.cqc.org.uk.

People's experience of using this service:
• The service met the characteristics for a rating of "outstanding" in the well-led key question and "good" in all other key questions.
• The service provided strong vision and leadership to a motivated staff team who felt valued by management.
• The service had robust quality assurance processes to measure, document, improve and evaluate the quality of care.
• The service was always investigating ways to develop and improve the experience of people who used the service.
• People benefitted from the service's connections with other health and social care agencies and community presence.
• People's privacy and dignity was respected by staff.
• Care planning documentation clearly identified people's diverse needs, preferences and choices.
• The service worked with other agencies to provide support to people at the end of their life in accordance with their wishes.
• People received personalised care which met their individual needs and were supported to express their wishes.
• People and relatives told us the service was compassionate and respected their preferences and decisions.
• Staff were knowledgeable and experienced. They received appropriate training and support to ensure they could carry out their roles effectively.
• More information is in the full report.

Rating at last inspection:
At the last inspection the service was rated Good overall and Requires Improvement in the effective key question (7 April 2015).

Why we inspected:
This inspection was part of our routine scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:
We will continue to monitor the service to ensure that people receive safe, high quality care. Further

inspections will be planned for future dates.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe? The service was safe Details are in our Safe findings below.	**Good**
Is the service effective? The service was effective Details are in our Effective findings below.	**Good**
Is the service caring? The service was caring Details are in our Caring findings below.	**Good**
Is the service responsive? The service was responsive Details are in our Responsive findings below.	**Good**
Is the service well-led? The service was exceptionally well-led Details are in our Well-Led findings below.	**Outstanding** ☆

Oxford House Community Care

Detailed findings

Background to this inspection

The inspection:
We carried out this inspection under Section 60 of the Health and Social Care Act 2008 (the Act) 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 Act, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Inspection team:
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.

Service and service type:
The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Not everyone using Oxford House Community Care receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

Notice of inspection:
We gave the service 48 hours' notice of the inspection visit so the manager had time to arrange gaining consent from people for us to shadow home visits. We also gave notice to the manager to ensure they would be available to assist us with our inspection.

Inspection site visit activity started on 31 January 2019 and ended on 7 February 2019. We visited the office location on both dates to see the manager and office staff; and to review care records and policies and

procedures.

What we did:
Our inspection was informed by evidence we already held about the service. We were aware of a safeguarding strategy meeting regarding the alleged neglect of a person using the service, so we looked at safe systems and mitigating actions during the inspection. We checked for feedback we received from members of the public, and local authorities. We checked records held by Companies House and the Information Commissioner's Office (ICO).

Due to technical problems, we did not ask the provider to complete a Provider Information Return. This is information we require providers to send us to give some key information about the service, what the service does well and improvements they plan to make. We took this into account when we inspected the service and made the judgements.

We telephoned 18 people using the service and 17 relatives on 31 January 2019 and 1 February 2019 to gather their feedback. We shadowed two different care workers during two homes visits. We spoke with the registered manager, eight care workers, the care manager, the care co-ordinator, one area supervisor, one senior care worker, the office support and the accountant. We emailed staff members, commissioners and other healthcare agencies to gather their feedback and received five responses.

We reviewed parts of 15 people's care records including care plans, risk assessments and medicines administration records. We checked five staff personnel files, 14 accident and incident reports and other records about the management of the service. After our inspection, we asked the registered manager to send us further documents which we received promptly and reviewed as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

Good: People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes to safeguard people from the risk of abuse
• People and relatives told us they felt safe using the service with comments such as, "I do feel safe. They are so sort of careful, willing and helpful. They are good", "I am definitely safe and comfortable. They are very helpful and very sympathetic" and "We feel very safe in their hands with this company."
• Staff undertook safeguarding training and demonstrated that they knew how to recognise abuse and protect people from the risk of harm. For example, a care worker told us they were concerned about one person's home circumstances and so reported this to service management who took further action. The care worker told us the outcome improved the person's situation and the person "appeared much happier."
• The service kept an up-to-date log of safeguarding referrals, reports, and outcomes. Agreed actions were implemented by the service and were reflected in updated care planning documentation.
• The service provided practical training in how to use different types of key safes (key kept in a locked, coded box) to promote secure access to people's properties. Staff confirmed this helped them with their confidence in using these safely.
• We saw in care documentation that people had safety alarms and could contact the provider 24 hrs by phone in an emergency.

Assessing risk, safety monitoring and management
• The service undertook and documented risk assessments in accordance with people's individual needs, which included identified hazards and measures to reduce risk. Risk assessments did not always determine the severity or likelihood of risks which is important to make sure control measures are proportionate. We discussed this with management who said they would review their documentation to include this approach.
• The service was proactive in accessing other agencies to improve the safety and security of people's homes. For example, the service coordinated the local authority's housing department and environmental health, which improved the safety of people's home environments and their quality of life.
• The service completed fire risk assessments and completed joint visits with the local fire service. This raised people's awareness and the service provided practical support to reduce risk, such as introducing appropriate bedding for people who chose to smoke.
• The service subscribed to the Thames Valley Police "Neighbourhood Daily Alerts" which provided an update of criminal activity within specific geographical areas. This information was shared in regular staff memos with instructions to be vigilant and provide advice to people regarding their safety and security.
• A 'body map' was completed when the service commenced for people to document existing marks on the skin and was used to monitor subsequent redness, bruising or broken skin. A care worker explained they would always report unexplained marking and seek medical advice for injuries.

Staffing and recruitment
• People were supported by a stable staff team who were familiar with people's needs. There were enough

staff rostered on to meet visits with zero agency used. We saw rotas were planned with dedicated teams in place to provide continuity of care.
• The service was supported by a well-resourced office-based staff team which included the registered home manager, a care manager, a care coordinator, four area supervisors, an office support worker and an accounts team. Senior staff covered care worker absence when needed and provided out of hours support.
• People's visits were logged using an electronic call monitoring system. This system facilitated a precise record of the duration of a home visit. The office-based co-ordinator monitored a 'real time' picture of the progress of home visits and whether the 'care checklist' essential to people's wellbeing had been completed. During home visits, we observed that the care workers logged in and out using a mobile phone device.
• If care workers were running late, people were informed via the provider's office. Visits were fulfilled in line with the provider's contingency plans for seasonal holidays and recent adverse weather conditions.
• Staff were recruited safely by the provider. A system was in place for appropriate checks of new applicants which included checks of identity, criminal history, completion of references, full employment histories and face-to-face interviews.

Using medicines safely
• The provider was following safe protocols for the receipt, storage, administration and disposal of medicines. The service encouraged the use of locked medicines boxes to improve security and continuity of support from care workers, with people's consent.
• Care workers supported the administration of medicines with different levels of support: assisting with medicine (prompting); administering (giving) medicines which was documented in peoples' care plans. We observed a care worker who followed the correct procedure for administering and recording medicines.
• We received feedback about two different medicines concerns during our inspection visit. We raised this with the registered manager who provided us with further information and evidence that the service followed medicines support according to people's wishes and agreed package of care. The service reviewed this with people, their GP and relatives to clarify their needs and support offered.
• Care workers completed medicine administration training for domiciliary care workers level 2 and were assessed for competency. We also saw that a care worker had undertaken level 3 training in the administration of Warfarin (a blood thinning medicine to treat or prevent blood clots).
• A care worker we spoke with was aware of special precautions for warfarin. They were able to cite Warfarin monitoring processes in place with the relevant healthcare agency and how this related to Warfarin dosage adjustments.

Preventing and controlling infection
• Staff had completed infection control training.
• During home visits, we observed that care workers used appropriate personal protective equipment (PPE). The service kept ample supplies of gloves in a variety of sizes.
• We reviewed the provider's infection control policy. This adhered to the code of practice for health and adult social care in prevention and control of infections and related guidance.

Learning lessons when things go wrong
• The service used a robust accident and incident recording system. Reports were consistently completed, reviewed by senior staff and signed-off by the registered manager and clearly documented findings, root cause analysis and outcomes. Agreed actions were followed-up and updated in people's care plans.
• Thematic reviews were undertaken and documented for falls, medicines events, and other accidents and incidents. This information was shared and discussed weekly at a senior team meeting, which fed into a review of policies and procedures and shaped the learning and development of the service.
• The provider had learnt from a previous incident involving self-neglect and were quick to recognise signs

and seek appropriate support from other agencies. The service had begun to implement a self-neglect assessment tool which identified risk factors such as mental health or substance misuse issues. This enabled the service to sign-post and support people to access other health and social care agencies proactively to avoid harm.

Good

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

Good: People's outcomes were consistently good, and people's feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law
• The service gathered as much information as possible about people and completed a detailed needs assessment before a new care package commenced.
• Assessments were holistic and included areas such as social and emotional wellbeing, people's backgrounds, preferences, interests and protected characteristics. For example, people's religious and cultural needs and preference of staff gender were identified and met.
• The service followed relevant national assessment tools such as the Waterlow pressure ulcer prevention tool and assessed people in line with national prevention of falls guidance.
• There was clear guidance and instructions within people's care plans about how to use equipment such as hoists and standing frames.

Staff support: induction, training, skills and experience
• People were supported by staff who had ongoing training. Staff received mandatory and specific training to meet people's individuals' needs. A high proportion of staff had achieved health and social care qualifications.
• People and relatives said staff were skilled with comments such as, "I think they are very competent and professional. My Mum has never complained about anybody", "Yes, I think they are skilled. We have a good supervisor who looks after the team in the area" and "[family member] is so frail and the carers are very gentle. They show professional skills in the way they handle her physically."
• The service accommodated the local authority (LA) to use the service's training facilities due to their well-resourced equipment and classroom. The LA used this for the reablement teams' moving and handling training and gave the service priority spaces for staff. Knowledge gained by staff from reablement methods benefitted people using the service who were supported to research and access new equipment with positive outcomes. For example, in one case this resulted in a person no longer experiencing falls.
• As part of their induction, staff 'new to care' were supported to complete the Care Certificate, which is a set of fifteen standards of knowledge, skills and behaviours expected of specific job roles in health and social care. New staff received feedback from their supervisor after the first and second months and from the care manager at three months.
• Staff received regular supervisions in the community and in the office and were given opportunities to review their individual work and development at annual appraisals.

Supporting people to eat and drink enough to maintain a balanced diet
• The service supported people to shop, prepare and cook meals where this was an identified need. People told us they were happy with the food staff prepared for them. One person said, "They cook what I want. The food is lovely, they cooked a full English breakfast for me this morning."

• The service followed appropriate eating and drinking guidance for people who required support. People's needs such as food intolerance and dietary requirements were clearly identified in individual's care plans and cross referenced with relevant healthcare professional's guidance.
• "Stage three thickened fluids" support and guidance were recorded in a person's care plan. However, there was not a risk assessment for the safe storage of thickener in the person's home which is important to avoid harm from accidental swallowing of the powder. We discussed this with the care manager who identified that no one was currently at risk but agreed they would review this in line with NHS guidance.
• Care workers were required to complete an electronic checklist which included hydration for each home visit. If this was not completed it was immediately flagged on the provider's system. We observed the care manager respond to one of these alerts by contacting the care worker, who confirmed that they had provided drinks but had accidently missed the check box.
• During shadowing visits, we observed that care workers ensured people had plenty of preferred fresh drinks within reach and with the appropriate equipment needed.

Staff working with other agencies to provide consistent, effective, timely care; Supporting people to live healthier lives, access healthcare services and support
• The service worked with other agencies and professionals to ensure people received effective care. For example, the service had immediately referred to and co-ordinated with the falls prevention clinic to assess a person's needs, we observed the care manager followed this up and information was shared in the electronic care records for care workers to read.
• Staff described the ways in which they followed health care practitioners' guidance successfully to and improved people's physical health. We looked at a sample of eight cases where people's support strategies were implemented and led to people achieving their health and wellbeing aims. In all cases this had a positive impact upon people's independence and social and emotional wellbeing.
• People and relatives told us that care workers supported them to access health care service when required. We were made aware that a care worker had provided cardiopulmonary resuscitation (CPR) to a person in advance of and with paramedics.
• There were specific protocols for staff to follow in sharing information with other health and social care professionals to ensure people's wellbeing. Contact with other healthcare agencies was recorded and any changes promptly recorded in care planning documentation.
• We received positive feedback from a local authority (LA) that the service was proactive and efficient in managing transitions where risk was minimised and no safeguarding concerns occurred.
• The service supported people to co-ordinate with the local authority to assess their changing needs and worked collaboratively to meet needs in line with agreed care packages.

Ensuring consent to care and treatment in line with law and guidance
• 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 checked whether the service was working within the principles of the MCA.
• People using the service did not currently meet the criteria for the mental capacity assessment. The service sought people's consent for the care and treatment provided which was recorded in care planning documentation.
• The service told us they did not complete their own mental capacity assessment or best interest pro-forma. They sought advice and support from the local authority if they had doubts about a person's mental capacity. We discussed this with management who agreed it would be appropriate to complete their own assessments for the care and support they were responsible for. The service promptly developed their own assessment in accordance with the mental capacity code of conduct, which was provided to us shortly after

our inspection visit.
• Staff had completed training in the Mental Capacity Act 2005 (MCA). Care workers we spoke with demonstrated sound understanding of mental capacity principles and sought people's permission in practice. One staff member we spoke with said, "I don't take consent for granted, I always ask. Dementia can fluctuate but there are other ways of adapting and presenting information to help with understanding."
• Another member of staff was aware of the role of the Court of Protection, and the appointment of deputies to make decisions when a person lacked mental capacity. The service used the government online facility to check if lasting power of attorneys (LPAs) were in place for health and welfare or finance and kept a record of this on file.

Good

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

Good: People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported; equality and diversity
• People we spoke with during home visits were positive about the service. We observed a good rapport between people and the care workers, who demonstrated knowledge and understanding of the person's family network and interests. A person told us "I've got a lovely carer. We get on very well together. I don't know what I'd do if I lost her."
• Staff spoke about people with kindness and demonstrated concern about individuals' wellbeing. Staff consistently told us that they would report even minor concerns about people's welfare immediately as a precaution and that senior staff and management acted upon concerns about people quickly.
• Staff were experienced in supporting people with diverse needs and spoke about people's preferences and choices respectfully.
• Staff told us they adapted communication depending on the person's ability and needs. For example, one member of staff told us they supported a person to express themselves by communicating in writing. Another care worker described how she always made sure that she positioned herself, so a person could read her lips and facial expressions which helped them to receive information.

Supporting people to express their views and be involved in making decisions about their care
• Care workers we spoke with all said they took time to listen to people and appreciated the value of "chit chat" and companionship. One person told us, "[Care workers] are all very directable. When they arrive, they listen to what I have to say and then off we go."
• The service regularly sign-posted and co-ordinated support from other agencies. For example, they had introduced a door to door transport agency to provide information and advice in accordance with a person's wishes.
• The service had directly corresponded with people and relatives to provide them with contact details of other health and social care agencies where relevant and followed this up in person.

Respecting and promoting people's privacy, dignity and independence
• Staff we spoke with were aware of how to protect people's privacy and dignity and spoke with sensitivity when describing how they supported people with physical or intimate care.
• In general people told us they felt their privacy and dignity was upheld by the service with comments such as, "They wait until I tell them that I am ready for them to do what they have to do. To be fair, they are very hot on dignity issues", "They respect my privacy. They always ask me first if they want to bring a trainee in" and "I don't like people giving me a bath, but I let them do it because they respect me. If I say no, I mean no and they respect any decision that I make."
• The service worked with people to maintain and promote their independence. People's abilities were identified in care planning documentation and staff demonstrated that they were focused on promoting

people's self-esteem through gentle encouragement and celebrating people's achievements.
• People told us staff treated them with compassion; "[Care workers] keep me warm and they make sure that I am comfortable again. They have always been absolutely amazing to me" and "The staff are really good because I suffer from panic attacks…they are really good at calming me down and distracting me. They give me a bit of confidence when I am feeling low."
• The care co-ordinator showed us the electronic rota system which included the facility to match staff based upon people's feedback, preferences and protected characteristics. We were told that visit times were scheduled to ensure they did not impact upon one person's prayer times.

Good

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that the service met people's needs

Good: People's needs were met through good organisation and delivery.

Planning personalised care to meet people's needs, preferences, interests and give them choice and control
• People and relatives told us they were involved in initial assessments and on-going reviews. Senior staff completed regular visits review care plans and ask people if they were happy with the care and support they received.
• Care planning documentation provided clear essential guidance to meet people's needs, aims and what was important to them, including their history and background, preferences and hobbies.
• The service was part way through implementing an electronic system for person-centred care records which improved the ability to keep up-to-date and accurate records and identified people's holistic needs. We received consistent positive feed-back from care workers who found it easy to use and thought it gave them more time to listen and talk with people.
• Care workers were able to access and to complete electronic daily records of care on each home visit on a mobile device. These records did not always capture the person's mood or behaviour. The care manager said they would adapt the check list to include this level of information and provide feedback to care workers.
• Relatives told us the service contacted them regarding any significant events such as health concerns or if their family member declined support. We received other feedback where the relative expected the service to contact them sooner about an issue. We discussed this with the provider who took swift action to resolve this.
• People with more complex care packages received additional weekly visits from one of the area supervisors which were in place to ensure that all visits and care and support occurred as planned.
• The service was persistent in building people's confidence and working creatively to access the community in accordance with people's interests. One relative fed-back, "Mum has been given a new lease of life with the carers…they have encouraged her to go to the Day Centre. She used to be in the house 24 hours a day, every day."
• The service identified people's information and communication needs by assessing them. Staff understood the Accessible Information Standard (AIS)This standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information communication support needs of people who use services. We saw evidence that the identified information and communication needs were met for individuals. For example, large print documentation was provided and people were matched with staff who shared the same language.

Improving care quality in response to complaints or concerns
• The service provided clear guidance and contact details for how to make a complaint within the "Service User Guide". People and relatives told us they could contact "office staff" to make a complaint if they needed to.
• The complaints procedure was in line with regulations and we saw that complaints were responded to

promptly and investigated. The provider's responses included apologies for any occasions when the service had fallen below the expected standard in line with the duty of candour regulation.
• A complaint that arose from an episode of care in late 2017 was being reviewed by the Local Government Ombudsman (LGO). The provider had investigated this complaint and responded promptly. However, the complainant chose to escalate the complaint and the service had shared information with the LGO as appropriate.
• The service kept a log of compliments which were reviewed by the senior team and fed-back to staff in their supervisions, appraisals and weekly staff memos.

End of life care and support
• Palliative care training had been completed by staff who supported people at the end of their life.
• The service was not currently supporting any one at the end of their life. However, during our inspection we were aware that the service was liaising with the district nurses team to co-ordinate this for one person and were in the process of gathering information about the person's needs and wishes.
• The registered manager informed us that for a person they had previously supported at the end of their life, the service had gone over and above and arranged to transport a person's relative along with care workers attending hospital visits, in accordance with their wishes.
• Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders were filed electronically. The service was following-up where a GP had not indicated who was involved in the decision on the form.

Outstanding ☆

Is the service well-led?

Our findings

Well-Led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture.

Outstanding: Service leadership was exceptional and distinctive. Leaders and the service culture they created drove and improved high-quality, person-centred care.

Working in partnership with others
• The service invested in building positive relationships with other agencies and took the initiative to lead multi-agency collaborations which people benefitted from.
• Management were extremely motivated and persisted to find solutions to meet people's complex needs and circumstances. They worked sensitively with people's employers, day centres, charities, and community healthcare teams. There were multiple cases where this led to positive outcomes for people. For example, the service worked discreetly with an employer which meant a person was able to maintain their independence, access to employment and dignity at work. Another person with a physical disability was supported to regain their independence by the service supporting them to co-ordinate and access improved mobility equipment and community services. This meant the person was no longer dependent upon care workers taking them to the shops and social events and improved their self esteem. The service was persistent in coordinating and attending health meetings to promote a person's right to equal access to healthcare treatment, which was previously denied to them. This led to successful treatment, avoided hospital admission and improved the person's long term health, independence and emotional wellbeing.
• The provider had established positive links with local authorities and was well respected. A local authority (LA) commissioner told us the service was open and honest and very professional, which resulted in safe and smooth transitions.
• The registered manager was invited to sit on a LA interview panel in 2018, which led to the appointment of a senior adult social care position. The registered manager also led the co-ordination of a recruitment event with another LA and other care providers.
• The service was involved with other local and governmental recruitment initiatives to attract more people to the sector. The care manager had delivered a series of workshops and presentations about care workers roles to job seekers, which had resulted in the service interviewing candidates.

Planning and promoting person-centred, high-quality care and support; and how the provider understands and acts on duty of candour responsibility
• The provider promoted and supported people to meet their personal goals. To achieve this, they placed great importance on service cohesion and continuity of care. This was tied into service strategies and literature and shared with people and the staff team.
• The service planned small dedicated support teams for people and managed contracts with LAs to prioritise staff capacity and continuity. This enabled the service to provide flexible support during the night for people with complex needs who were at high risk.
• The service was focused upon achieving zero missed calls. We saw from the provider's records that there were only three missed visits from a total of 225,000 in 2018. This data corresponded with the notifications

the service sent to us where required.
• People using the service told us, "I think Oxford House is one of the best companies I have been with. If you have an issue, you can ring up and they will sort it out. This is the one company that I have had no major issues with. I think it is a well-run company and I am happy with the service", "This is a miracle, the service they provide because it is a great help to all of the family. We feel that we don't have to worry because they come on time…Me and my wife and Mum has been given a new lease of life because she enjoys chatting to the carers and seeing people outside of the family" and "What they do best is the communication between the carers and the service users. If the relationship is good then the rest will run smoothly."
• Without exception staff we spoke with demonstrated they were passionate about supporting people to achieve their unique goals and took great pride in their work.
• The provider was open and transparent with people using the service. For example, the service wrote to people about significant events with explanation, an apology (where appropriate) and details of what the service was doing to maintain standards of care.
• The service reviewed business contingency plans in line with government health and social care Brexit no-deal guidance to optimise continuity.
• The service promoted equality and diversity for people using the service and amongst its staff team. There were up-to-date Equal Opportunities and Equality and Diversity policies which were in line with Equality Act (2010). The service went further and provided documented "Implications for Care" guidance to meet diverse needs. This included specific information of what routines staff needed to observe to meet people's religious and cultural needs, or how to wash types of hair for people from different backgrounds and so on.
• The service arranged Punjabi medicines training in response to feedback from staff and the trainer to enhance staff comprehension of technical clinical jargon. This led to the successful completion of medicines training and competency assessments.
• Care plans and other service literature were translated and provided in Punjabi for people using the service who required this.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements
• Management were experienced and knowledgeable of regulations, national guidance and aspired to provide an exemplary service. The provider always reported notifiable events to the Care Quality Commission and was quick to provide further information if required.
• People's care records, staff and management documentation was very well organised, accessible and up-to-date.
• There was a clear organisational structure which was well resourced. Staff files indicated a robust process for initial and ongoing training, including shadowing competency assessments and performance reviews. The registered manager conducted every employee's annual appraisal to value staff directly.
• The care manager and area supervisors had detailed knowledge of people's needs and were able to provide relevant advice and support to care workers.
• Staff consistently told us they felt extremely supported and were able to approach senior staff to raise issues. One employee said, "We have so much back up and support here… [the manager's] door is always open."
• There was a comprehensive system of spot checks and audits. Data was analysed for thematic trends which fed-into the provider's "Forward Plan". This plan identified time-specific areas for development which was regularly monitored by the registered manager and demonstrated systematic progress.
• Monthly "Punctuality" reports were reviewed and categorised by the provider to assist with root cause analysis. This information was shared and discussed in senior meetings and fed-into strategies to meet the service punctuality aims.

Engaging and involving people using the service, the public and staff, fully considering their equality

characteristics
• The service highly valued people's feedback and took a proactive approach in gathering information via ongoing service user and staff surveys, which the provider analysed and acted upon.
• We saw overall satisfaction results since August 2018 had improved to 100%, which was sustained up to and including December 2018 (the provider was in the process of receiving returns for January 2019). The results were published on the provider's website and shared with their local authority partners.
• Management were always looking at ways to gain feedback from staff who the registered manager described as the "eyes and ears" of the service. There was a general open-door policy but to promote this further the service had recently implemented an "Open Office" event every other Wednesday. The aim was to encourage staff to drop in for an informal catch-up with office staff and to share their views.
• Staff told us that management listened to their ideas. For example, during our inspection staff told us they shared their learning from a medicines training session that day with the care manager. This was added to the senior meeting agenda to discuss and review the procedure.
• The service provided staff with weekly memos which included information about training opportunities and career progression, up-dates to national guidance, best practice and general service performance feedback. For example, a January 2019 memo included information and advice for EU nationals in a Brexit no-deal. There was a reminder to check upon vulnerable people in the cold weather and what to do if staff were concerned.
• There were several schemes in place to acknowledge and reward staff for their performance and loyalty to the service. This included an annual awards event where staff received recognition and gifts for their individual achievements and there was also a staff discount scheme. One member of staff told us, "I won an award due to good feedback from people using the service. I feel very encouraged and very happy and I will stay with the company." We saw that a significant proportion of staff had longevity with the service.

Continuous learning and improving care
• The provider invested in learning to kept abreast of changes and developments in adult social care. For example, the care manager had recently attended high-level safeguarding training and was incorporating learning into service processes.
• The service subscribed to the "Dementia Friends" scheme to learn and share best practice with staff. The care manager was booked to attend a seminar in February 2019 and planned to review support strategies and share learning with staff.
• The provider valued the ability for staff to share experiences and discuss scenarios in a classroom-based setting to optimise learning and therefore completely avoided the use of online training.
• The service was selected to pilot local authority projects which developed outcome-based care and commissioning strategies. The registered manager delivered presentations to LAs about their experiences to share what they had learnt.
• The provider had a structured plan to link-up with its partner nursing home to improve social opportunities for people using its service in the community.
• The service had liaised with a dedicated pharmacy system to offer continuity and improve safety and planned to consult with people and offer this service later in the year.
• Plans were underway to introduce a service user "Homecare Newsletter" in the forthcoming months as another route to share organisational performance information and advice about other agencies and services.