

Berkeley Home Health Limited

Berkeley Home Health Sussex

Inspection report

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Date of inspection visit:
28 November 2018
17 December 2018

Date of publication:
28 February 2019

Ratings

Overall rating for this service

Requires Improvement 

Is the service safe?

Requires Improvement 

Is the service effective?

Good 

Is the service caring?

Good 

Is the service responsive?

Requires Improvement 

Is the service well-led?

Requires Improvement 

Summary of findings

Overall summary

Berkeley Home Health - Sussex is a domiciliary care agency registered to provide personal care to people living in their own houses. It is registered to provide care to those living with dementia, physical disabilities and sensory impairments.

This comprehensive inspection took place on 28 November and 17 December 2018 and was announced. This was the first inspection of this service since it was registered on 29 November 2017.

Not everyone using this service receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care, which means help with tasks related to personal hygiene and eating. Where people receive personal care we also consider any wider social care provided. At the time of our inspection the service supported 39 people with their personal care needs.

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager left the service in November 2018, and the service was undergoing changes because of merging with another Berkeley Home Health branch. The service was being run by the business manager who was in the process of undergoing registration with the CQC. We have referred to this person as the acting manager throughout this report. The acting manager was being supported by the regional director.

Risks to people were considered, but not always consistently assessed. Care plans were not always consistent and up to date. People did not always receive care that was personalised and responsive to their needs. People did not feel their concerns were always responded to. People said they did not always receive care at their preferred times. Quality monitoring had identified some areas that required improvement that we found on inspection but not all.

We have made a recommendation that the provider develops quality monitoring processes further to ensure they are embedded. We have made a recommendation that the provider engage with people to gather feedback with respect to timeliness of their care visits.

People and staff told us that under new management improvements to the service were being made. Systems and processes to ensure management oversight of the service and monitor quality had identified some of the issues we found on inspection. The acting manager, supported by the regional director, had a comprehensive improvement plan in place. We did not find these inconsistencies had impacted on people's safety, but these improvements needed more time to be embedded and sustained.

People told us they felt safe. One person told us, "My carers are good, I am lucky to have them." People were

supported to receive their medicines safely by staff that were trained in administering medicines. People were protected by the prevention and control of infection.

People were protected from avoidable harm. There was a safeguarding policy and staff received training. Staff knew how to recognise the potential signs of abuse and knew what action to take to keep people safe.

People were supported to have maximum choice and control of their lives and staff support them in the least restrictive way possible; the policies and systems in the service support this practice. Staff understood best interest decision making where people lacked capacity in line with the principles of the Mental Capacity Act 2005. Staff sought people's consent before giving personal care.

There were sufficient numbers of suitable staff to meet the needs of people. Staff had the skills, knowledge and experience to carry out their duties. A relative told us, "Yes, they do seem to have good training." People were supported to maintain their health and had assistance to access health care services when they needed to.

People received kind and compassionate care. People told us the staff were kind and caring and there were positive interactions between people and the staff caring for them. One person said, "They are very kind, they really do care."

Staff said they enjoyed working for the service and felt supported by the acting manager. The service was going through a period of change, areas for improvement had been identified by the management team, and action was being taken to address them. The acting manager had an improvement plan to ensure people who used the service and staff felt supported through a period of transition. This included listening to feedback to ensure people, relatives and staff were engaged and involved in the service provided.

Further information is in the detailed findings below.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement 

The service was not always safe.

Risks to people were considered, but not always consistently assessed. We did not find this had resulted in harm to people.

The provider had policies and procedures for safeguarding people from possible abuse and neglect. Staff knew how to recognise the signs and they knew what to do if they suspected any abuse had occurred.

Sufficient numbers of staff were provided to meet people's needs.

People received their medicines safely.

Is the service effective?

Good 

The service was effective.

Staff received an induction when they started work and were trained in relevant areas.

Consent to care and treatment was sought by staff on a daily basis, and staff understood their responsibilities with regard to the Mental Capacity Act 2005.

People were supported to eat and drink enough when needed and could exercise choice.

People were supported access other health care services.

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Is the service caring?

Good 

The service was caring.

People received kind and compassionate care and were treated with respect.

People's dignity and independence was respected and

promoted.

People were supported to make choices about their care.

Is the service responsive?

The service was not always responsive.

Care plans were not always consistent, up to date and responsive to people's needs.

People did not always receive their care at their preferred time.

People knew how to complain and felt comfortable to do so, but said their concerns were not always addressed.

The provider was taking action to address these issues.

Requires Improvement ●

Is the service well-led?

The service was not always well led.

Systems and processes for monitoring the quality of the service had identified areas for improvement, but needed more time to be embedded and sustained.

People said communication was not always good, though this was improving under new management.

Staff enjoyed working for the service and felt supported by new management, despite going through a period of change.

Requires Improvement ●

Berkeley Home Health Sussex

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 comprehensive inspection took place on 28 November and 17 December 2018 and was announced. We gave the provider 48 hours' notice of the inspection visit, because the location provides a domiciliary care service and we needed to be sure the manager, staff and people we needed to speak to were available. The inspection team consisted of one inspector, an assistant inspector and an Expert by Experience. An Expert by Experience is a person who has a personal experience of using or caring for someone who uses this type of care services.

Before the inspection we reviewed information we held about the service including any notifications complaints or safeguarding alerts that we had received. A notification is information about important events which the service is required to send to us by law. We contacted other health and social care professionals who have experience of the provider to obtain their views. We used information the provider sent us in the 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.

During our inspection we spoke with eight people who used the service and one relative. We looked at three care plans and we pathway tracked the care of one person. Pathway tracking is where we check that the care detailed in individual plans matches the experience of the person receiving care. During the inspection we spoke to the acting manager, the regional director and seven staff. We looked at a range of documents including policies and procedures such as safeguarding, incident and accident records, medication protocols and quality assurance information. We looked at complaints and compliments and feedback from people who used the service. We reviewed three staff files including information about recruitment and

training.

Is the service safe?

Our findings

Risks to people's safety were considered, but not always consistently assessed. As part of an initial assessment of people's care needs, the provider used range of tools to assess risks to people such as a safe moving and handling, or a mobility assessment to manage the person's risk of falls, or monitoring to maintain people's skin integrity. Care plans did not reflect a consistent approach to risk assessment. Risk assessments for some people were detailed and timely, but others were not or were not clear. For example, one person who received 24-hour care suffered a fall at night, which caused them serious injury. The person had received appropriate medical treatment and this included an assessment from an occupational therapist (OT) following their fall. This had prompted a moving and handling assessment, but this had been completed six months after the incident and did not give clear guidance to staff on how to mitigate the person's risk of falling at night. For example, the assessment identified that the person had a risk of falling at night, and stated the advice from the OT. This included that the person should have access to use of a commode at night in their bedroom due to their unsteadiness. However, in a different section of the care plan it stated the person needed support from staff when using the commode, but this was not included in guidance to staff on managing the person's risk of falling at night. Following our inspection, the acting manager completed a new assessment of this person's risks and confirmed they had suffered no further falls since this incident.

People received their medicines by staff who were trained and competent to do so, but risk assessment of medicine was not consistently managed. For example, one person had a detailed risk assessment for medication in their care plan, including "as and when" medication. However, another person living with dementia did not have a risk assessment around medication in their care plan, despite their medication carrying specific risks. Staff received regular training to ensure their practice remained safe. Some people managed their own medication, but other people needed support with their medication. We checked the Medicine Administration Records (MAR) for people who needed support, in care plans and in one person's home, and found these were correctly recorded. The provider was introducing a new MAR chart design and staff were due to receive training in January 2019.

We did not see evidence that these inconsistencies had resulted in harm to people. We discussed the inconsistencies in care plans in relation to risk assessments with the acting manager and regional director, who recognised the potential risk to people meant this was an area of practice that needed to improve. The service shared with us results of a recent audit they had undertaken of all aspects of the service following the change of manager, and this had identified several areas for improvement. This included a review of all care plans and risk assessments to ensure they were up to date and consistent. The regional director shared their action plan and records showed this was being implemented.

People were protected against the risks of potential abuse. Staff showed awareness of the potential signs of different types of abuse. They told us they would not hesitate to report any bad practice they witnessed or suspected, and they would report it to a manager or external agency straight away. Staff received training, a safeguarding policy was available and staff understood safeguarding adults' procedures and what to do if they suspected any type of abuse. One staff member said, "I would log it down and report it to the office."

Another staff member said, "I would find out what has happened and then call my manager." The provider also had a whistleblowing policy which staff were aware of and gave staff access to an independent service called Speak Out where staff could raise any concerns anonymously.

People had confidence in the staff caring for them and they told us they felt safe. One person said, "I have two carers who are very good, I am lucky to have them." Another person said, "They are trustworthy and a joy to be around." One person who had complex health needs that required specialist equipment told us that they trusted the staff to use the equipment appropriately and to keep them safe.

There were sufficient numbers of staff to meet people's needs. The regional director and staff told us that the service had been through a period of reduced staffing, but this had now improved. Staff told us that they had enough to meet people's needs safely. One staff member said, "At the moment we have enough staff for the amount of clients we have." Another staff member said, "Yes, we have enough staff to cover the calls." Staff told us they had enough time on visits. One staff member told us, "I always have the right amount of time with people." People told us they had sufficient time for their visits.

The provider had processes to ensure new staff were suitable to work with the people. Recruitment processes included obtaining previous work history and written references from previous employers to assure themselves of a candidate's suitability. Photographic records were also on file to confirm staff member's identities. Records showed that checks had been made with the Disclosure and Barring Service (DBS). DBS checks identify if prospective staff have a criminal record or are barred from working with people who use care and support services. New staff completed an induction and this included a period of shadowing experienced staff before being assessed as competent to work with people. The service had recently introduced a check list for office staff to complete for new starters to ensure a robust and consistent recruitment process was always followed.

Risks associated with the safety of the environment and equipment were identified and managed appropriately. Environmental hazards were considered in people's homes as part of an assessment of their needs.

People were protected by the prevention and control of infection. People told us that staff always used Personal Protective Equipment (PPE) such as gloves and washed hands and we observed this in practice. Staff received training and told us they had access to PPE at all times.

Lessons were learnt from accidents and incidents. There was a system in place to record accidents and incidents with information about what had happened, and any action taken to prevent a further accident as far as possible. Learning was shared across several of the provider's other branches. For example, we saw minutes from a managers meeting in November 2018 where recent incidents were discussed and learning points identified to be shared with staff.

Is the service effective?

Our findings

People told us they were confident in the skills of staff. One person said, "Oh yes, they are adequately trained, they know what they are doing." Another person told us, "We get newer people, and they seem to be getting the right training and come along to learn the ropes." Staff had the skills, knowledge and competency to deliver effective care and support. There was a training plan that covered a broad range of areas and the acting manager had an overview and awareness of the status of staff training. There was an action plan in place to ensure staff training remained up to date. Training was delivered in different ways; some training was online and other training was face to face. Staff had mixed views about their preferred method of training but all had an induction before they started to work with people, and staff said this prepared them to carry out their duties. One person said, "They seem to be well trained, the new ones shadow the experienced ones." One staff member said, "I learnt about hoisting as I'd never done that before. I feel confident now on this." A relative told us, "Yes, they do seem to have good training, if someone comes in as a stand in they seem to be able to step in fine." The acting manager told us that specialist training from external providers was available where people had specific care needs. Another staff member said, "I could always ask them for extra training."

People continued to be supported to maintain good health and received on-going healthcare support. People had access to care, support and treatment in a timely way and the service liaised appropriately with social and health services when people's needs changed. People received support from occupational therapists, community nurses, speech and language therapists and others such as the local falls prevention team. For example, a member of staff told us about one person who had recently been in hospital with pneumonia. Staff received information from the hospital as well as a handover from the community nursing team. The staff member said, "They went through it with me. If I'm not sure I will always ring up to confirm." In response to the specific needs of some people who used the service, the acting manager had a plan to introduce specialist training in diabetes and workshops for staff via the Dementia Friends and Dignity in Care networks to ensure best practice guidelines were followed.

The acting manager ensured staff received appropriate professional development and supervision to meet the needs of the people they cared for. Staff received regular supervision and staff underwent reviews of their practice. Staff told us they felt supported and recognised the part that regular scheduled supervision played. Staff said, "I am supported, especially the new manager." Another staff member said, "The managers are always in contact, they act on our suggestions straightway." The acting manager had a plan to develop staff supervision in more depth to further support staff.

People's care, treatment and support was to be delivered in line with current legislation and standards. The Mental Capacity Act 2005 (MCA) provides a legal framework for making 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 decisions, any made on their behalf must be in their best interests and as least restrictive as possible. We checked whether the provider was working within the principles of the MCA.

Care plans were sufficiently detailed with respect to MCA. Initial assessments prior to people receiving care included whether people could make decisions for themselves. Consideration was given to whether people were supported by others to make decisions, such as an advocate or a person with legal authority to do so such as a Power of Attorney. Where there was concern about a person's capacity, best interest discussions were documented and we saw people were consulted appropriately. For example, one person's capacity was re-assessed following an incident. Best interest discussions were documented that were decision specific around particular aspects of the person's care. The care plan appropriately documented involvement with the person's Power of Attorney for health and welfare. Staff files confirmed that MCA training formed part of essential training and the provider had introduced annual competency assessments to ensure staff understood the principles of the MCA. Staff talked knowledgeably about the people they cared for, and how they supported people who lacked capacity or where their capacity may fluctuate. One staff member told us about one person they cared for who lived with dementia, "My daily tasks is to make sure she remembers her food and drink. I assume capacity as much as possible and ask her for her consent, ask her if she wants a drink etc."

People and their relatives told us that staff always sought consent before delivering care. One person said, "The carers always ask my permission with any personal care, they are very respectful." Where people had capacity to make decisions for themselves, they were supported to be engaged in their care. One staff member said, "Consent can be given in multiple ways. We have a client who can't talk and I look out for physical communication like moving to do something when they want it done."

People continued to be supported to eat and drink enough to maintain a balanced diet. One person said, "I do my own meals, but they will always make me a cuppa when they're here." Where the service supported people with eating and meal preparation, this was detailed in their care plan. People could exercise choice over what they ate. One person said, "They help me but yes, I always choose my meals."

Is the service caring?

Our findings

People told us they were treated with dignity and respect. One person told us, "I do feel they treat you with respect, yes." A relative said, "The carers have a great respect with him, they encourage him with his speech which he really struggles with, but they communicate very well with him." Staff called people by their preferred name and described how they maintained people's dignity during personal care. For example, one staff member said, "I close the curtains and cover the person up. I close doors when family members are around." Another staff member said, "You make sure you're asking them for their consent, and make sure they are kept informed as to what you are doing." A relative told us, "They do respect his dignity yes, they keep him covered up and give him privacy." We visited one person in their home and observed the care they received and their interactions with staff were genuinely warm, caring and kind. Staff observed good infection control practice, checked if there were any changes to the person's care needs and asked for consent before giving any personal care.

People received kind and compassionate care and staff had developed positive relationships with people. One person said, "We do get along very well, it's nice to have someone to chat to, it can be a long day without visitors." Another person said, "They are very kind, they really do care." Staff expressed genuine affection for the people they cared for. One staff member said, "We have a client, I talk to him about his job which puts him at ease. People like talking about their home life and their family. You want to make sure you treat them just how you would want your relatives treated." Staff told us how they made sure people knew that they cared, and that they had a positive impact on the person. One staff member said, "I sit with them, ask them how they are, get to know them, making sure they are ok."

People were supported to make choices about their care. Staff told us they asked people how they wanted things done and we saw this in practice. For example, we observed one care visit where staff did their best to maintain the person's dignity, despite working in a small space which was challenging. The acting manager told us the person was very particular about how they liked things to be done, such as how furniture was arranged while personal care was being given, and staff respected the person's wishes. People were supported to maintain their independence as much as possible. One staff member told us, "We have a client we used to do everything for. I get him to do his personal care and slowly encourage him to more bits and pieces where he can. I leave a bit of water in the kettle, so he can make himself a cup of tea."

Staff understood equality, diversity and human rights. Care plans included people's preferences, for example regards gender and religion where they wished to discuss them, and staff told us that people were free to talk about their beliefs. People's differences were respected and were supported to maintain their identity. One member of staff told us about a person who liked music and theatre, "I can engage with him on that, I use the environment to get clues as to what they can share with you."

People's private information was secure. Care documentation was held confidentially and systems and processes protected people's private information. Sensitive information was stored securely in the office which was locked when staff were not present.

Is the service responsive?

Our findings

People we spoke to had mixed views about whether they always received their care that was responsive to their needs at their preferred time. One person told us, "I do feel rushed yes, it's the nature of the game, they always run late, so have to make up time when they can." Other people said, "It frustrates me they are always so rushed" and "they are often late but only by 10 minutes or so" and "The main carers are kind but always rushed." However, other people said, "They never rush his appointment" and "they can occasionally be late and will call if its more than 15 minutes late." The provider made arrangements to deliver rotas to people every week but some people told us they did not always receive a rota for their care visits. People told us that in the past there was a lack of staff, but the service was starting to improve under new management.

Staff told us they had sufficient time on their calls. One staff member said, "The length of calls is fine. I don't have a problem, I have a fairly regular round." Another staff member said, "At one point there wasn't enough, but they've got this sorted. I always have the right amount of time with people." Staff told us that the service had gone through a period of transition after several staff had left but that the service was improving. One staff member said, "At one point we had too many clients, not enough staff." Another staff member told us, "At the moment we have enough staff for the number of clients we have. If we took on more, we would need more."

After the inspection the provider supplied an audit of call times for three people who use the service which showed they received their calls at their preferred time. However, people we spoke to had mixed views about whether they received their care consistently at their preferred times. We recommend that the provider engage with people who use the service to obtain their feedback around the timeliness of their care visits and take the appropriate action.

People told us they were involved in developing their care plans but people did not always receive regular reviews of their care as planned. Assessments were carried out before providing personal care for people and people's preferences were recorded. However, the care plans we reviewed varied in the level of detail they contained, and information was not consistently kept up to date. For example, one person's care plan had very detailed information about their preferred daily routines and information about their personal history, likes and dislikes. However, another person's care plan contained very limited information. The provider's policy was that care plans were reviewed every six months, sooner if the person's care needs changed. Staff told us they had access to the care plan before supporting people, but that they needed updating. Staff comments about care plans included, "They are okay, they do need updating, the office is in the process of doing that" and "at the moment they really need updating, the simple fact of people's routines are often not completely up to date. I know that at the minute the managers are updating them."

People gave mixed views on whether the provider was responsive to concerns. One person said, "There is little and poor communication from the office and if you do moan, nothing is done about it." However other people said that they had no cause to complain. The providers complaints procedure to was available for people and their relatives to view. Records showed that action had been taken recently to improve

communicate with people about the provider's complaint process.

We spoke to the acting manager and regional director about these areas of practice that required improvement. Both the acting manager and regional director were transparent with us about the fact the service had been through a period of transition, including merging with another Berkeley Home Health branch. The service had also suffered a period of staff losses and as a result the service had not always been able to provide care that was responsive to people's needs. The acting manager shared a comprehensive audit of the service and results from a survey from November 2018, which had identified the issues we had found on inspection with respect to care planning. The provider developed an improvement plan in response and records showed that these planned improvements were underway. Both people and staff told us that these changes were beginning to impact the service positively. One member of staff said, "The care plans have got a lot better. We have a new care plan in the book, they are coming from a more person-centred way, they are so much better because you get much more of an understanding when you read it from the client's point of view." One person told us, "A lot of staff left, but since then I've had three main carers come, which is nice to have a regular face." While improvements were being implemented, they need time to be embedded and sustained.

Care continued to be person centred with respect to people's healthcare needs. Records of referrals to and visits from healthcare professionals in people's care files with detailed guidance for staff, such as speech and language therapists (SALT), GP's, occupational therapists and community nurses. Staff were proactive where they felt the person needed additional support. For example, one staff member said, "I was caring for a lady who had surgery a few weeks prior. She was ready to have showers, she was unsteady in herself ... she hadn't done it for so long, I thought it was too much for her. I rang the office and said the environment wasn't good enough and they needed to put in handles. The occupational therapist assessed it and put in the new equipment."

The provider had incorporated the Accessible Information Standard (AIS) when assessing people's needs. AIS is the standard that aims to make sure that people who have a disability, impairment or sensory loss get information that they can access and understand, and any communication support that they need from health and care services. Providers must identify, record, flag, share and meet people's information and communication needs in line with section 250 of the Health and Social Care Act 2012. All organisations that provide NHS care or adult social care must follow the Standard in full from 1st August 2016 onwards. Care plans showed people's sensory and communication needs were being recorded where appropriate.

Staff who had been working with Berkeley Home Health for some time knew the people they looked after well. Staff identified that activities and interests were an integral part of people's lives and understood this was important to providing person centred care. One member of staff told us about a person who liked to go out and visit their friends in the evening, so they always ensured they left the person's coat next to them.

Is the service well-led?

Our findings

The service did not have a registered manager. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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. The registered manager left the service in November 2018, and the service was undergoing changes because of merging with another Berkeley Home Health branch. When we inspected the service, the business manager had been recruited to the role and was undergoing the CQC process to be registered as manager. In this report we have referred to this role as acting manager. The acting manager was undergoing a training program to prepare them for the role and was being supported by the regional director.

Systems and processes were in place to assess, monitor and improve the quality of the service being delivered, though these needed more time to be embedded. The provider undertook routine monthly audits of certain aspects of the service, such as daily notes and MAR charts, with care plans undergoing reviews every six months. However, following the departure of the registered manager, the provider had undertaken a comprehensive audit of the service and this had identified a broad range of areas that needed to improve. The provider had developed a comprehensive improvement plan to address these issues, and records showed that this was being actioned. Some of the issues we identified on inspection had already been identified by the provider, though others had not. For example, the acting manager and regional director were not aware that one person had fallen and sustained injury six months previously. Although the person had received the appropriate medical care, the provider's audit process had not identified this incident. When we discussed this with the acting manager on inspection, action was taken immediately to address this. Similarly, the audit had identified inconsistencies in care plan documentation and a failure to undertake regular reviews. However, audit of care plans had not identified specific inconsistencies such as medication risk assessments or a failure to properly assess people's communication needs. This meant that despite quality monitoring systems, these did not give the acting manager complete oversight of all aspects of the service.

Both the acting manager and regional director were transparent throughout the inspection process and it was clear steps were being taken to address areas that required improvement. We recommend that quality monitoring processes needed to be developed further to ensure management oversight become embedded and sustained.

People told us that they did not always feel engaged and involved by the management of the service, though this was improving. People told us in the past they did not feel the management of the service was visible and they did not feel the office staff were always responsive to any issues they raised. People told us that they did not always get their rotas and communication with the office had not been good. One person said, "There is poor communication from the office." Another person expressed concern about the merging of two branches, "I've heard rumours that they are going to close the branch and I'll be left without carers." We spoke to the acting manager and regional director about how the service engaged with people. The acting manager told us they were personally visiting every client to discuss the merging of the two branches,

as part of their care reviews. Records showed that the provider had engaged people via a survey in November 2018 and responses to the survey were consistent with what the people we spoke to told us. Records showed that the provider had listened to people's concerns and an action plan was in place to address these issues, including actively seeking ways to improve communication. For example, the regional director was personally undertaking calls to all people who use the service to understand people's concerns. While improvements were being made in the way people were engaged with the service and involved with their care, these changes needed time to be embedded and sustained.

Despite recent changes, staff spoke positively about Berkeley Home Health and that they felt supported by the new management. The acting manager told us that the merging of two branches had been challenging to get staff together, but that they aspired to build a culture of "a local service for local people." One member of staff told us, "It has got a lot better in the last few months, the acting manager has been absolutely brilliant." Another staff member told us that staff morale was "going up, it was on a low... with the new management we know things will be acted upon straight away." Another member of staff said, "I feel supported, especially by the new manager, she's always there for us." Staff felt engaged in the service, and were invited to provide feedback through staff meetings and staff surveys. Records showed that where staff raised concerns or provided suggestions, these were listed to and where appropriate acted upon. A recent survey of staff identified several areas where staff felt improvement was required. The acting manager had an action plan to address these issues. In addition, good work was recognised and rewarded. Staff were thanked for their service in a variety of ways including a carer of the month scheme, nominated by people who use the service and their relatives.

Staff continued to work in partnership with other agencies to ensure people's needs were met. We saw that the acting manager and staff had developed relationships with a variety of healthcare professionals to meet people's needs. This included GP's, community nursing teams, community rehabilitation and falls prevention teams as well speech and language specialists and occupational therapists.