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1st React Healthcare - 1st React Healthcare Domicilary Care Agency

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We carried out an announced comprehensive inspection of this service on 25 and 31 October 2017. 1st React Healthcare Domiciliary Care Agency is registered to provide personal care to people living in their own homes. The agency provides care to people living in Exmouth and the surrounding areas. When we visited, the service provided a personal care service for 42 people.

We previously inspected the service on 27 and 28 July 2016. At that inspection the service was rated requires improvement overall as the safe, effective, responsive and well led domains were rated requires improvement. The caring domain was rated as good. Three breaches of regulations were identified at the previous inspection related to medicines management, person centred care, and good governance. The service sent us an action plan to show how they would improve in these areas.

At this inspection, we found improvements in medicines management, person centred care, and in quality monitoring.

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

Medicine systems had improved so people received their medicines safely and on time. All staff had regular competency assessments to check their medicines management skills and knowledge. People felt safe using the service and said it was reliable. Regular care staff visited them who they got to know and trust. Concerns were identified about staff rotas with overlaps in people's visit times which meant staff couldn't be on time for some visits. We have made a recommendation about improvements needed in this area.

Staff knew about the signs of abuse, how to report concerns and their responsibilities to protect people. The service had not notified the Care Quality Commission (CQC) about three concerns about suspected abuse, although these had been appropriately dealt with the local authority safeguarding team. A notification is information about important events which the service is required to send us by law. The registered manager and provider are now aware of their responsibilities and have since sent us retrospective notifications. Staff were aware of risks and people's risk assessments identified steps staff needed to take to promote people's safety and welfare. Recruitment processes ensured people were cared for by suitable staff.

Staff had the skills and training needed to carry out their role and undertook regular training relevant to needs of people they cared for. People confirmed staff sought their consent before providing any care. Where people lacked capacity, staff demonstrated a good understanding of the Mental Capacity Act (MCA) (2005) and how this applied to their practice.

Staff developed positive and caring relationships with people. Care staff were motivated, people mattered

and staff spoke with kindness and compassion about the people they supported. People confirmed staff respected their privacy and treated them with dignity and respect.

People's care was individualised to their needs. Staff enabled people to remain as independent as possible. People's care plans had improved, were more personalised, detailed and comprehensive and described positive ways in which staff could support them. People knew how to raise any concerns or complaints and felt confident to do so and action was taken in response to make improvements.

The culture of the service was open; people, relatives, professionals and staff were positive about leadership at the agency. Care and office staff worked well together as a team. The provider and registered manager worked well together, promoted good standards of care and developed the staff team. The service had a range of quality monitoring systems which included spot checks, regular review meetings, audits and surveys. They made continuous improvements in response to their findings.

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

One aspect of the service was not safe.

Most people and relatives said the service was reliable, although concerns were identified about timeliness of some visits. Rota planning issues did not ensure staff could be on time for all their visits.

Staff knew about their responsibilities to safeguard people and how to report suspected abuse.

Improvements in medicines management had been made and people received their medicines in a safe way.

Risks for people were assessed and actions taken to reduce them.

A robust recruitment process was in place to ensure people were cared for by suitable staff.

Is the service effective?

Good

The service was effective.

Systems to check staff's practice in people's homes had improved and were used to check that all staff were undertaking their duties as required.

People were cared for by staff who received training and supervision which enabled them to have the skills to meet people's needs.

Staff recognised changes in people's health, sought professional advice appropriately and followed that advice.

Staff sought people's consent for care. Where people lacked capacity, their legal rights were protected because staff understood the requirements of the Mental Capacity Act (MCA) 2005 and acted in accordance with it.

People were supported with their nutrition and hydration needs.

Is the service caring?

Good

The service was caring.

People and relatives said staff were caring and compassionate and treated them with dignity and respect.

People were able to express their views and be actively involved in decisions about their care.

People were supported by staff they knew and had developed good relationships with.

Staff protected people's privacy and supported them sensitively with their personal care needs.

Is the service responsive?

Good

The service was responsive.

Care plans had improved and were more detailed to guide care staff about how to meet people's individual needs.

People received individualised care and support that met their needs and promoted their independence.

People knew how to raise concerns and complaints, and were provided with information about how to do so. Any concerns raised were investigated and improvements were made in response.

Is the service well-led?

Good

The service was well led..

Improvements in monitoring the quality of people's care had been made with positive actions taken in response to the findings of audits and spot checks of staff practice.

The provider and registered manager set standards for staff who worked well as a team and felt well supported.

People and staff views were sought and suggestions were taken into account to improve the service.

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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 checked whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection was announced and took place over two days on 25 and 31 October 2017. We gave the provider 48 hours' notice because the location provides a domiciliary care service and we needed to make sure the provider and registered manager would be available during our inspection. The inspection team comprised of an adult social care inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses services for older people.

The provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We reviewed the information included in the PIR along with information we held about the service, such as the provider's action plan, feedback we received from health and social care professionals and notifications. A notification is information about important events which the service is required to send us by law. This enabled us to ensure we were addressing any potential areas of concern.

We sent thirteen questionnaires to people and their relatives and seven (54%) were returned. We sent eighteen questionnaires to staff and four (22%) were returned. During the inspection we visited two people in their own homes. We contacted ten people and four relatives by telephone to ask them their views about the service. We looked at four people's care records and at four medicine records.

We spoke with the provider, registered manager and eight staff which included care staff, office staff, a co-ordinator and a supervisor. We looked at five staff files which included details of recruitment, training, supervision and appraisals. We also looked at staff meeting minutes, staff training records, accident and incident reports, and complaints and compliments. We looked at audits of medicines, care records and at spot checks carried out on care staff providing care in people's homes. We sought feedback from commissioners, and health and social care professionals such as social workers and occupational therapists and received a response from three of them.

Requires Improvement

Is the service safe?

Our findings

At the previous inspection increased risks for people were identified in relation to medicines management. This was because medicine administration records (MAR) lacked information about the dose, frequency and quantity to ensure the medicines were administered safely. At this inspection we found improvements in medicines management and the requirement was met.

Three allegations of suspected abuse were identified since the last inspection which were reported to the local authority safeguarding team with appropriate action to protect people. However, these were not reported to the Care Quality Commission (CQC) as required by the regulations. We showed the new registered manager how to access the information regarding these notifications. At our request, these notifications were sent in retrospectively, with details of the actions taken to protect people.

Staff had received safeguarding adults training and the provider had safeguarding and whistle blowing policies in place. This meant staff knew who to contact and what to do if they suspected or witnessed abuse or poor practice. Care staff were knowledgeable about how to recognise signs of potential abuse. They knew who to report concerns to, including the management team and other agencies. There was an up to date copy of the service's safeguarding policy and procedure, which included guidance from the local authority.

The CQC had been contacted about the timeliness of staff visits and staff not staying for the required visit time. The agency standard was that staff would within 15 minutes of the planned visit time. Six people we contacted during the inspection had experienced some difficulties about timeliness of visits. Comments included; "They are supposed to come at 9.30 and this morning it was 11, one night it was 10pm (supposed to be 8.30 to 9pm); "They are booked for nine o' clock, but often it will be ten"; "One lunchtime this week, it's supposed to be 1pm call and it got to 2.30pm, I phoned the office and she said she would be here in a minute". The (care staff) had 2pm on her rota, so it was a miscommunication. Three people said staff did not always stay for the full visit time, but said they were happy their needs had been met. One said, "They stay as long as there is something for them to do." A social care professional speaking about one person's experience said staff regularly did not stay for the paid and agreed time, so the person felt they were being "short changed." They were following this concern up directly with the agency.

86% of people who responded to our questionnaire said staff arrived on time, and 71% said they stayed for the agreed visit time. Where changes in rotas were made, or care staff were delayed, people said office staff usually (but not always) informed them about any changes.

A random selection of people and staff rotas week commencing 16 and 23 October 2017 identified several issues with visit times. Some showed overlapping visit times, which meant care staff were scheduled to visit two people at the same time. For example, a member of care staff was due to visit one person from 9am to 10 am and the next person from 9.30am to 10.30am. Another member of staff was due to finish at 7.45 am with one person and arrive at 7.30 to be second member of staff for a person needing two care staff. Three staff said these overlaps happened quite often.

Care staff received weekly rotas showing their planned visits, but some staff said their rotas were changed regularly. When staff were off sick, visits were redistributed between available staff. The registered manager had a system to calculate staffing levels needed, which was about 275 hours per week. They said there were sufficient staff to meet the current number of care hours needed, and confirmed rota issues identified were mostly related to short term sickness. Other reasons given for changing visit times included temporary increases in people's care needs, and new people just starting the service, who didn't yet have a regular team of care staff.

We recommend further action is taken to ensure staff rotas do not have overlapping visit times.

Some visits had no travelling time calculated between visits. A member of the office staff said travel time was not always needed when people lived in the same building or very close to one another. When we checked the rotas with those people's addresses, this explained some, but not all of our concerns. This meant rota planning did not ensure staff could be on time for all their visits. Since the inspection the provider has contacted us to confirm the electronic rota system allocates travelling time to each visit.

We asked about contingency planning, for example to cover short term sickness or weather related problems. Some staff worked extra hours and all office based staff were trained to provide care which meant they could help with visits where there were any staffing difficulties. A 24 hour on call system provided people and staff with support and advice by the management team out of hours, which people reported positively about.

People responded positively to our survey with regards to feeling safe. One person said, "I feel perfectly safe." Most people and relatives said the service was reliable, they received a weekly rota which informed them about their visit times and showed which care staff would be visiting. People had a regular group of care staff they got to know and trust. One person said, "The majority of the time it's the regular ones." Where people needed two care staff they confirmed these were always provided.

Improvements in medicines management had been made and people received their medicines in a safe and appropriate way. People's assessments made clear what level of staff support people needed with their medicines. For example, staff gave some people their medicines and checked with others to make sure they had remembered to take their tablets.

MAR sheets now included details of prescribing information, and daily signatures confirmed when medicines had been given. Staff had undergone further training to familiarise them with the medicines management policies and procedures. All staff had competency assessments to check their medicines management skills and knowledge. Detailed information leaflets about prescribed creams and drops had been obtained for staff. MAR sheets were audited monthly by the provider. Where any errors, such as gaps in signatures were identified, these were followed up and addressed with individual staff. For example, through retraining and reassessment.

Risks to people's personal safety had been assessed and plans were in place to minimise risks. For example, people at risk from skin damage due to their frailty and reduced mobility. Detailed risk assessments provided staff with information about how to reduce these risks through detailed moving and handling instructions, information about skin care, the number of staff and equipment needed for repositioning. Two people said they felt safe when staff were using hoist equipment to move them. One said, "They are always asking are you alright, do you feel comfortable?"

Environmental risk assessments were in place which highlighted how to reduce risks for people and staff.

Examples of risks included pets, security, household chemicals, furniture and equipment. To improve personal safety for staff, they had been issued with a personal alarm, torch, and for staff visiting on foot reflective clothing.

Reported accidents/incidents were reviewed and actions taken to prevent the risk of recurrence. For example, through additional staff training and increased supervision. Where an error had occurred, a letter of apology was sent to the person including an explanation and action take to prevent a similar mistake happening again.

People were protected from cross infection. People said care staff washed their hands before and after providing personal care and wore gloves and aprons. 100% of people responded positively to our questionnaire about use of hand washing, gloves and aprons to prevent and control infection. All staff were issued with hand washing gel and 'spots checks' included monitoring how standards of hygiene were maintained.

A robust recruitment process was used to recruit new staff and included assessing knowledge, skills and attitudes of applicants before care workers began to work for the agency. Checks included undertaking checks of identity, qualifications, seeking references and undertaking Disclosure and Barring Service (DBS) criminal record checks. The DBS helps employers make safer recruitment decisions and helps prevent unsuitable people from working with people who use care and support services.

Good

Is the service effective?

Our findings

At the previous inspection improvements were needed to ensure all staff regularly received training and supervision. At this inspection we found improvements had been made. The registered manager had developed a training matrix to monitor completion of training and participation in supervision. This showed all staff undertook required training and had regular supervision.

People and their relatives said care workers had the knowledge and skills to meet their needs. One person said, "They are very good. I can't fault them." Another said, "The other day the manager had to come because my main carer was getting me into the shower and they wanted to check on health and safety. He has learned the system, and she checked again and was happy."

Staff gave us positive feedback about their training and development which enabled them to carry out their role. Staff training records showed all staff had regular training and updating and opportunities to undertake further qualifications in care. For example, medicine administration, safeguarding, Mental Capacity Act, first aid, food hygiene, infection control and health and safety. Staff had opportunities to complete additional training courses relevant to people's individual needs, such as dementia awareness, and end of life care. The registered manager had undertaken a moving and handling training course, so could train and update staff on moving and handling and use of equipment. New care staff felt well supported. They received induction training when they first began working at the agency and 'shadowed' experienced care staff until they felt confident to work on their own. Staff new to care completed the Care Certificate, a set of national standards that social care and health workers should demonstrate in their daily working life.

Staff had regular supervision through one to one meetings and the registered manager and care co-ordinator undertook unannounced 'spot checks' of staff in people's homes. These monitored a wide range of skills and standards such as communication, uniform, privacy and dignity issues, moving and handling, infection control, medicines management and record keeping. Detailed records were kept of positive feedback and of any areas identified for improvement, so these could be followed up. Annual appraisals gave staff feedback on their performance and identified further professional development opportunities. This helped to ensure staff were providing effective care and maintaining high standards of practice.

In the provider information return, the registered manager outlined how a staff member had recently taken a lead role in supporting staff caring for people living with dementia. The staff member had completed Alzheimer's Society "Dementia friends" training and was planning to run awareness raising sessions for other staff. These would enable staff to learn more about dementia and share best practice tips for supporting people. The staff newsletter featured a story raising awareness about the challenges for people living with dementia. For one person living with dementia, the staff member had worked with their family to complete a life story about the person's family history, previous job and lifetime memories. This helped staff talk to the person about relevant things of interest to them, which is good practice. The registered manager told us about plans to introduce "Life histories" for other people living with dementia, so staff had more personalised information about them.

People and relatives said care staff offered them choices and always sought their agreement before providing their care. One person said, "Yes, they always ask "What do you want today, a strip wash or a shower?"

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found they were.

Where people lacked capacity or had memory problems, staff gave us examples of how they supported people to make as many choices and decisions for themselves as possible. For example, in relation to choosing what to have for breakfast or what clothes to wear that day. Where people were assessed as not having the capacity to make a decision, staff involved people who knew the person well and other professionals, such as their GP in making best interest decisions. Systems and documentation were in place for capturing mental capacity assessments and recording best interest decisions. Details were kept about relatives or others with a lasting power of attorney for health and welfare or financial decisions, so staff knew who to consult and involve.

Staff supported people with their ongoing healthcare needs. For example, by arranging appointments with health professionals, and for some people ordering and collecting medicines. Where any changes in health needs were identified, staff liaised with health professionals and updated care plans with any new treatment decisions. Professionals said staff recognised changes in people's health and sought health professional advice appropriately and followed their advice. For example, staff contacted the community nurse to check a person with a red area on their skin.

Where people had any assistance with food or drink they were happy with the support they received. For example, encouraging some people to eat and drink during the visit, leaving a sandwich or making sure people had enough drinks for the night time. This helped ensure people remained healthy through good nutrition and hydration.

Good

Is the service caring?

Our findings

People said staff were kind and caring and developed positive relationships with them. Comments included; "Yes, they have been really, really good, really kind and supportive;" "She's like a mother to me." The provider information return showed the agency had received 10 written compliments in the past 12 months. These included; "I would like to thank you for your amazing care and thoughtfulness, he looked forward to seeing their happy faces every morning;" "Thank you all for giving great care to my father." People were sent cards to mark and celebrate their birthday, which showed was thoughtful.

Staff supported people to express their views and be involved in decisions about their care and support needs. Everyone who responded to the CQC survey confirmed they were involved in decision making about their care. When people first joined the service, a member of office staff met with them and if wished family members to find what support they needed. This ensured people's views and preferences were listened to and taken into account in planning their care.

People were asked about whether they had any preferences for how staff referred to them and whether or not they were happy to have male or female care staff. People said staff treated them with dignity and respected their privacy. For example, knocking and announcing their arrival before coming in, pulling curtains and making sure the door was closed when the person was in the shower.

Care staff were motivated, people mattered and staff spoke with kindness and compassion about the people they supported. People's care records included personalised details about how each person wanted to receive their care and support. Staff promoted people to remain as independent as possible. For example, helping one person to exercise to maintain their mobility, and encouraging another person to wash their own hands and face and brush their hair, only assisting them with washing the areas they needed help with.

An information pack was given to each person including details of services they may find useful such as a key safe, mobility equipment, frozen meals, personal alarm, and local carer support and dementia support. Information for people was provided in a variety of formats according to individual needs. For example, for a person with a learning disability, staff had used pictures and symbols to write to the person about arrangements they had made to get their grass cut regularly. People were sent a quarterly newsletter with information and updates about the agency, which was available in other formats such as large print.

One member of staff with experience in end of life care had taken on a lead role to support other staff to care for people approaching the end of their lives. Relatives commented positively about people's end of life care. Comments included; "Many thanks for the kind care and support, we are so pleased with your help he was able to stay at home which meant so much to him and us;"
"Mum was cared for with care and dignity throughout …chat and even laughter. The support team made a difficult, tiring and emotional time so much easier to bear."

Good

Is the service responsive?

Our findings

At the last inspection people's care plans were not detailed enough and did not include all the necessary information staff needed to meet people's needs. Improvements in care plans had been made to include more details about how to support individual people including their preferences. For example, in relation to moving and handling, pressure area care and preferred personal care routines.

People said staff who visited knew them well and how to support them in ways that met their individual needs. One person said, "It takes two to three visits before there are fully 'au fait'." Another said, "We have worked out between us a very good schedule of how things should happen, how best to get me changed."

People and relatives were involved in developing their care plans and in reviewing and updating them. People signed their care plans to confirm they agreed with their content. Senior staff visited people regularly to review people's care and check the care provided was still meeting their needs.
Care records were updated as people's needs changed. For example, in relation to catheter care, and with details of how to use moving and handling equipment such as a slide sheet to safely reposition a person. For another person, with swallowing difficulties, a nutrition care plan was updated about preparing foods in a safe way safe for the person to eat following assessment and recommendations made by a speech and language therapist. We discussed with the registered manager and provider how more details about each person's life, hobbies and interests, would help newer care staff to get to know people and communicate with them. They planned to make further improvements to include that information.

The agency responded flexibly to changes in people's care needs. For example, one person said the agency increased their visits to four times a day to support their increased care needs when they came out of hospital. For another person, care staff increased their visits to provide additional support, whilst the person's main carer went into hospital for planned surgery.

People were made aware of the complaints system and each person had information on how to raise a complaint in the folder kept in their home. People and relatives said communication with the office was good and when messages were left, staff got back to them promptly.

One complaint had been made in the past twelve months. This was fully investigated, with a follow up letter with apologies offered where care fell below expected standards, and contained the details given of improvements being taken in response. The complainant said they were satisfied with the actions taken in response.

Good

Is the service well-led?

Our findings

At the last inspection, gaps in quality monitoring were identified as audits had not identified areas needing improvement such as care plans and medicine records. At this inspection improvements had been made in these areas and in other aspects of quality monitoring. Since the inspection, the registered manager and provider have demonstrated they are now aware of their responsibilities to notify CQC about suspected abuse and have since sent us three notifications.

Since the last inspection a new registered manager had been appointed who was in day to day charge of the service. The provider worked part time at the service to support the registered manager and undertook some monthly audits including medicines. A deputy manager, care co-ordinator and two supervisors also helped with staff supervision, rotas and 'spot checks' of care practice.

Most feedback from people, relatives and staff was positive about the service. One person said, "I think the organisation, from my point of view, do very well. The girls are very pleasant, they take notice, do as I ask." Another person said, "I love 1st react because they listen to me. My care workers are good and helpful I couldn't wish for better."

Asked about areas for improvement some people said they were not always informed of changes of staff, or of timings of visits. Other comments included; "Scheduling problems need to be sorted; "Sometimes they come late;" and "They should stick to the times."

The service had just implemented electronic monitoring, which used staff mobile phones to monitor the time staff arrived and left each person's house. This meant, in future, office staff would be better able to monitor the timeliness and duration of each visit, and be alerted to any missed visits or rota timing errors. The new system also showed a staff member's location, so in the event they have not arrived at their expected destination, action could be taken. People no longer needed to sign timesheets to confirm staff arrival and departure times, as this was captured electronically.

Staff said they worked well together as a team and felt supported and valued for their work. They understood their role and what was expected of them. Throughout our visit care staff were dropping in to the office to update the registered manager and office staff about people's care and any changes. They were positive about working for the agency, the support and training and development opportunities. One said, "It's a good agency, friendly and we provide good care," and another said, "Support for everyone, friendly and flexible."

A social care professional said, "We work with 1st React often and I think we have good communication." Another professional said, "The care given by staff is excellent. I have no complaints or concerns about 1st React. The manager is very good to work with and I feel she takes on what I say and works with me to find solutions to things that come up."

The service had a range of quality monitoring systems which included regular review meetings, 'spot

checks,' audits of medicines management and care records. They made continuous improvements in response to their findings. For example, the registered manager had improved monitoring systems for staff training and was tackling improving sickness absence through monitoring. They met with individual staff and discussed ways to support them, for example, following bereavement and in relation to returning to work after a period of sickness.

Monthly quality monitoring reports were sent to a lead agency that commissioned services from 1st React on behalf on the local authority. This reported on key performance indicators such as staff turnover, accidents, incidents and complaints. Regular management meetings were held which discussed concerns, areas for improvement highlighted and identified any training needs. Where any practice issues were identified these were addressed through supervision and training. Where incidents had occurred, steps were taken to improve practice and reduce the risk of recurrence.

The provider information return highlighted the service had developed a staff newsletter to feedback changes and updates to staff. For example, the Autumn/Winter 2017 newsletter included a welcome to new staff, training details and information about the introduction of a new electronic staff monitoring system. A staff handbook outlined significant information for staff about key policies and procedures. Regular staff meetings were held to give feedback to staff, as well as seek their views and ideas. Staff satisfaction surveys were carried which included identifying areas needing further improvement. For example, for office staff to improve electronic records of telephone conversations with people, relatives and staff.

People were regularly asked for their feedback about the service through regular care review meetings, and via quarterly surveys. These were based on the CQC's five key question areas, safe, effective, caring, responsive and well led. Comments included; "Staff friendly, kind and respectful, we feel fortunate that the quality of care is so fitted to our need," and "(staff name) is a credit to your organisation." Responses to the surveys were positive However response rates were low. So changes had been made to improve the questionnaire in areas people and relatives had difficulty understanding and in response to requests to survey less frequently. When the registered manager received negative comments about the service, they offered to visit the person to discuss the improvements needed.

The service worked in partnership with other agencies for people's benefit. For example, agency staff contributed to discussions about people's changing care needs with other professionals such as GPs, community nurses and other staff such as occupational therapists and physiotherapists.

The agency provided evidence based policies and procedures to guide agency staff in their practice. In the provider information return, the registered manager highlighted how they looked at the CQC reports for services rated as 'Outstanding' for ideas on how they could further improve the service. For example, implementing lead roles in raising awareness of good practice in caring for people living with dementia and in end of life care.

People's care records were kept securely and confidentially, and in accordance with the legislative requirements. All record systems relevant to the running of the service were well organised and reviewed regularly. The agency displayed their CQC rating from the previous inspection in the branch office and on their website. This meant the public and staff were kept informed, in accordance with the regulations.