Medicare Home Support Limited

Caremark Norwich

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

The inspection was announced and took place on 11 September 2017. We have not inspected Caremark Norwich since a change in their registration, (legal entity) in July 2016. New services are assessed to check they are likely to be safe, effective, caring, responsive and well-led. As such, they had not yet received a CQC rating.

Caremark Norwich is a domiciliary care agency which provides personal care to people with a variety of needs including older people, people living with dementia, younger adults, people with a learning disability and/or physical disability. The agency's office is located in Norwich. At the time of our inspection, the service was providing personal care to 77 people.

A newly appointed manager was in post, who had recently registered with Care Quality Commission in August 2017. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

We received mixed feedback regarding people receiving calls at their preferred time and how the office communicated with people and their relatives about this and when changes were made to rotas. We discussed this with the provider and registered manager who offered explanations as to why this had been highlighted. We have discussed these issues within the Well-Led section of this report and recommended the provider reviews how they communicate with people and their relatives about what they are able to provide, regarding times of care calls and when changes are made to allocated staff.

People and healthcare assistants spoke highly of the care co-ordinators and the company. People expressed satisfaction with the service they received. However, we found that quality assurance systems were not always being used to ensure accurate records were maintained and to drive improvements. We identified there was a delay in daily notes and medication administration records (MAR) being delivered to the office from people's homes which could delay timely quality monitoring of those records. The provider updated their audit tool on the day of inspection to improve this; however we will need to assess how this improvement has been embedded and sustained at our next inspection. We found no evidence that the lack of audits and gaps in records had affected the quality of service people received.

Risks to people's wellbeing and safety had been effectively mitigated. We found individual risks had been assessed and recorded in people's care plans. Examples of risk assessments relating to personal care included moving and handling, nutrition, falls and continence support. Health care needs were met well, with prompt referrals made when necessary.

People told us they felt safe receiving the care and support provided by the service. Staff understood and knew the signs of potential abuse and knew what to do if they needed to raise a safeguarding concern.

Training schedules confirmed staff had received training in safeguarding adults at risk.

Robust recruitment and selection procedures were in place and appropriate checks had been made before staff began work at the service. This contributed to protecting people from the employment of staff who were not suitable to work in care. There were enough staff to protect people's health, safety and welfare in a consistent and reliable way.

Policies and procedures were in place to ensure the safe ordering, administration, storage and disposal of medicines. Medicines were managed safely.

The management team and staff had an understanding of the Mental Capacity Act 2005 and consent to care and treatment.

People chose their own food and drink and were supported to maintain a balanced diet where this was required.

People said staff were caring and kind and their individual needs were met. Staff knew people well and demonstrated they had a good understanding of people's needs and choices. Staff treated people with kindness, compassion and respect. Staff recognised people's right to privacy and promoted their dignity.

We looked at care records and found good standards of person centred care planning. Care plans represented people's needs, preferences and life stories to enable staff to fully understand people's needs and wishes. The good level of person centred care meant people led independent lifestyles, maintained relationships and were fully involved in the local community.

There was a complaints policy and information regarding the complaints procedure was available. There was one complaint in the past 12 months. Records demonstrated this was listened to, investigated in a timely manner, and used to improve the service. Feedback from people was positive regarding the standard of care they received.

Staff felt supported by management, they said they were well trained and understood what was expected of them. Staff were encouraged to provide feedback and report concerns to improve the service.

The provider had developed an open and positive culture, which focused on improving the experience for people and staff. The provider welcomed suggestions for improvement and acted on these. At this inspection we found the registered manager open to feedback and enthusiastic about providing a high standard of care to people. The registered manager had introduced systems to promote good practice. Field care supervisors had been introduced who provided consistency in the delivery of care and an additional link between the office and people being supported in their own homes.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People had detailed care plans, which included an assessment of risk. These contained sufficient detail to inform staff of risk factors and appropriate responses.

People were supported by trained staff who knew what action to take if they suspected abuse was taking place.

There were enough staff to cover calls and ensure people received a reliable service. Safe recruitment systems were in place.

People's medicines were managed safely.

Is the service effective?

Good

The service was effective.

Staff had received training and supervision to carry out their roles.

Consent to care and treatment was sought in line with legislation and guidance. Staff understood the requirements of the Mental Capacity Act (MCA) 2005 and put this into practice.

Staff protected people from the risk of poor nutrition and dehydration.

People had their health needs met and were referred to healthcare professionals promptly when needed.

Is the service caring?

Good

The service was caring.

People were supported by kind and caring staff who knew them well. People involved in all aspects of their care and in their care plans.

People were treated with dignity and respect by staff who took the time to listen and communicate.

People were encouraged to express their views and to make choices.

Is the service responsive?

Good

The service was responsive.

Care plans provided detailed information to staff on people's care needs and how they wished to be supported.

People's needs were assessed prior to them receiving a service.

People were provided with information on how to raise a concern or complaint.

Is the service well-led?

Requires Improvement

The service was not always well-led.

We have recommended that the provider revisit how they share and communicate information with people and their relatives regarding limitations the service has regarding timings of care calls. This includes when changes are made to rotas.

A range of audit processes were in place to measure the quality of the service provided. However, improvements could be made to the timely monitoring of care records.

Staff were supported and listened to by the registered manager. They were clear about their responsibilities.

The provider and registered manager was keen to make positive changes to improve the quality of care provided to people.

Caremark Norwich

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 11 September 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to ensure that someone would be available. The inspection team consisted of one inspector and an expert-by-experience with experience in adult social care. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete 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 looked at the notifications and other intelligence the Care Quality Commission had received about the home. This included statutory notifications sent to us by the provider about incidents and events that had occurred at the service. A notification is information about important events, which the service is required to send to us by law. In addition the Care Quality Commission had sent questionnaires to people using the service to gain their views on the care they received from the service. We reviewed 14 questionnaire responses from people, 11 responses from staff and two responses from people's relatives. We used all this information to help us decide which areas to focus on during our inspection.

During our inspection, we went to the office and spoke with the provider and registered manager. We also spoke with the two care coordinators, two field supervisors and two healthcare assistants.

We reviewed the care records of five people receiving support. We looked at service records including five staff recruitment, supervision and training records. Policies and procedures, complaints and compliments records and records of checks that had been completed to monitor the quality of the service being delivered.

On the 13 and 14 September, the expert-by-experience made phone calls to 20 people and one relative to

request their feedback about what it was like to receive care from the staff at Caremark Norwich. They agreed for their comments to be included in this report.

Good

Is the service safe?

Our findings

Without exception every person we spoke with told us they felt safe receiving support from Caremark Norwich. The following examples were given as to why people felt safe. One person said, "I am very safe. I need four double up calls a day due to my mobility and feel very safe in their hands when they are moving me about." Another person told us, "Yes I do feel safe. All the carer's that come are all very good. They are very careful with me and I am safe in the knowledge that I only have to ask them for anything and they will see to it." A third person told us, "Yes I can't fault them. They put on my compression stockings; I can't do that myself and then cream my legs. They are very careful when doing it ensuring I am safely seated down and cannot fall."

People were protected from the risk of abuse because staff understood the different types of abuse and how to identify these and protect them. Safeguarding policies were in place with additional policies on entering and leaving people's homes, handling their monies and property, confidentiality and dealing with emergencies. Policies provided underpinning guidance for staff to follow. Training records showed all staff had attended safeguarding training annually. Staff told us all concerns would be reported to the registered manager. If concerns related to the provider, they would report them to the appropriate local safeguarding authority or the CQC. One staff member told us, "Safeguarding means to protect people. If an allegation of abuse were made, I would report this to the office immediately. I would ensure it was reported to the safeguarding team, manager and the Commission." Another staff member told us, "Any alleged abuse needs to be reported to the manager. We have a duty to protect people and make sure they are getting the right support. Once it is reported it should be shared with safeguarding and yourselves [The CQC], possibly even the police depending on the abuse."

Risks to people's wellbeing and safety had been managed effectively. We found individual risks had been assessed and recorded in people's care plans. There were comprehensive risk assessments, which covered the internal environment of the person's home, risks of falls, nutrition and hydration, and continence information. Visual checks were completed on equipment such as bathing and shower equipment. Additional risk assessments were completed in relation to people's specific needs. For example, one person had moving and handling needs. The assessment identified that two care workers were required to assist the person safely and this was provided. There was sufficient guidance for staff to support the person safely. The care plans were reviewed if there were any changes in the person's care needs. This helped to ensure staff had access to up to date information about supporting people safely.

Accidents and incidents were recorded and the registered manager was informed if there had been any incidents. Staff told us they understood the process for reporting and dealing with accidents and incidents. If one occurred, they would inform the office staff and an accident form would be completed. We looked at the accidents and incidents for 2017. These records clearly stated what actions were taken to keep the person safe. However, the registered manager was unable to show how they analysed and learnt from accidents and incidents. We found that the nature of accident and incidents that had occurred were not repeated ones and therefore found this had not impacted on people's safety.

There were sufficient staff to meet people's needs safely. Staffing levels matched what was planned on the staff rota system. The office was open between 9am and 5pm from Monday to Friday with on-call cover 24 hours, seven days a week, in case of an emergency. People told us that they felt there were enough staff and that the care/support provided was done in a timely manner. However, some people shared their frustrations with their care worker arriving late and the lack of communication from the office surrounding this. Some people told us they did not know what staff were going to deliver their support until a week beforehand which led them to feel anxious. We fed back these comments to the provider and registered manager for their review. Whilst this did not seem to impact on the safety of people we have referred to it further in the Well-Led section of this report.

People were protected, as far as possible, by safe recruitment practices. Staff files confirmed that, before new members of staff were allowed to start work, checks were made on their previous employment history and with the Disclosure and Barring Service (DBS). The DBS provides criminal records checks and helps employers make safer recruitment decisions. In addition, two references were obtained from current and past employers. These measures helped to ensure that new staff were safe to work with adults at risk.

People told us they felt staff receiving support from staff with their medications. One person told us, "What really makes me feel safe is that they [staff] always check I have took my pills, as I can forget, and that puts my mind at rest." Another person told us, "Yes they [staff] do my medication, they are very good with them. They get them out for me and make sure I swallow them safely with a glass of water." A third person told us, "I do my own medication but they do remind me to take my inhaler which I can forget about."

People's medication administration records (MAR) were accurate and clear. Staff received medicines training and were able to describe how they safely supported people with their medicines. Training records confirmed that all staff received medication training. Medicine assessments considered the arrangements for the supply and collection of medicines. They included whether the person was able to access their medicine in their own home and what if any risks were associated with this. Staff were aware of the provider's policies on the management of medicines and followed these. Staff had a good understanding of why people needed their medicines and how to administer them safely. MAR charts contained clear guidance about the use of medicines prescribed for occasional use, such as for pain relief or anxiety. However, we identified there was a delay in MARs being delivered to the office from people's homes. MARs were audited by field care supervisors, upon delivery to the office. Whilst this did not seem to impact on the safety of people we have referred to it further in the Well-Led section of this report.

Good

Is the service effective?

Our findings

People told us staff were competent to meet their needs. One person told us "Yes I think they are all well trained. You can tell from the way that they handle me safely when washing me they know what they are doing." Another person told us, "You need to know what to with compression stockings as they are not easy and they put them on gently and well." Another person told us, "Very well trained in my opinion. I have double up calls and you know by the way they lift and move me they have the skills and knowledge to do it safely." A fourth person told us, "Oh yes very much so. They know how to help me with my rollator (this is a mobility aid) and ensure I am upright when showering and creaming me as I must not bend." A relative told us, "Definitely without a doubt well trained and skilled. The way they support, handle and treat [person] with so much respect shows they are all excellently well trained."

All new staff completed an induction, which included all generic and specific training to enable staff to carry out their role. They shadowed staff that were more experienced and did not work on their own until they were competent and confident to do so. New staff were enrolled on the Care Certificate (Skills for Care). The Care Certificate is a work based achievement aimed at staff who are new to working in the health and social care field. It offers an opportunity for providers to provide knowledge and assess the competencies of their staff. The Care Certificate covers 15 essential health and social care topics, with the aim that this would be completed within 12 weeks of employment.

Staff received training considered as mandatory by the provider in food hygiene, infection control, health and safety, first aid, moving and handling, and in the Mental Capacity Act 2005 (MCA). Training was refreshed as needed and certificates in staff files confirmed the training staff had completed. Additional training was provided for staff to meet people's specific needs such as dementia awareness, fluids and nutrition training.

In addition to the training provided, the field supervisor carried out unannounced 'spot check' visits on all staff approximately every six weeks. The field care supervisor was responsible for supporting staff in the community and providing a link between care staff and the office. During spot checks the field care supervisor observed how the staff member carried out their role and responsibilities on that particular care visit. Records demonstrated the field supervisor gave staff feedback on the spot if anything could be improved to their practice. Records confirmed staff received four supervision's per year and an annual appraisal; this gave staff an opportunity to discuss people they were supporting, their own support needs, areas for development and any further training.

The registered manager told us staff meetings were more difficult to arrange due to staff and their commitments to care visits and personal circumstances. However, one staff meeting had taken place in June 2017. This was an opportunity for staff to come together and discuss work related issues. The service employed two field care supervisors to enhance communication flow between people and the office and provide the necessary support to care staff. They were also able to step in and cover care calls if staff were absent or an additional need arose, which we observed in practice.

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.

Without exception every person we spoke with told us, they felt involved and that their views and decisions were respected by staff. One person told us, "Yes they [staff] always ask what I would like; sometimes they will get me breakfast if I want it but they have never done anything without asking first." Another person told us, "As I receive 24 hour support in my own house they [staff] always ask what I want before doing it, even cleaning." Another person told us, "I have two outings a week with them [staff] and one day shopping. They always ask where I would like to go and it is completely my choice." A fourth person told us, "They [staff] always ask if I am alright and is there anything else they can do. They won't do anything without asking me first and I respect that."

Care plans contained mental capacity assessments. Staff had a good understanding of mental capacity and put this into practice to ensure people's rights were respected. A staff member told us, "The Act itself states the individual we are supporting can make their own decisions. That it should be assumed they have capacity unless something indicates different. No one can take this away unless assessed otherwise. For example, a diabetic may choose to eat food that could potentially make them feel unwell." Another staff member told us, "We must assume each person has capacity. We need to respect people's choices and not force them to do our will."

Professionals from the local authority had completed MCA assessments for people when necessary for people who lacked capacity to agree to the care provided. During this process, a record was also maintained of best interest decision making processes that involved people who were involved in the person's life. Assessments were decision specific and were in line with the MCA code of practice.

People told us that where it was a part of their care package staff supported them to eat and drink enough. The support people received varied depending on people's individual circumstances. Some people lived with family members who prepared meals. Staff reheated and ensured meals were accessible to people who received a service from the agency. Records demonstrated other people required greater support, which included staff preparing and serving cooked meals, snacks and drinks.

Staff supported people to access advice about their health and welfare. One person told us, "Yes they [staff] take me to the doctors if required and wait until I have finished and they have also assisted me with making appointments with the optician. They even came with me and helped me to choose my specs! How good is that." The care plans included key contact details of people's next of kin, social worker, GP, district nurse and relatives. People with more complex needs had additional contact details of healthcare professionals such as occupational therapists, dieticians and the Speech and Language Therapy (SALT) team. Staff said and records confirmed that any changes in a person's behaviour or if someone was ill when they arrived would be reported to the office immediately to obtain advice and support from relevant healthcare professionals.

Good

Is the service caring?

Our findings

Without exception every person we spoke with told us they were treated with kindness and respect by the care workers who supported them. Comments included, "Very happy with it. They are all caring and we have laugh and I get on well with them all." "I can't fault it. They are all very polite and very friendly and helpful in all ways." "Excellent service. Had them for a couple of years now. They are all caring in their aspect toward me." "Happy with the service. They are all caring and encourage me to do things for myself which is good toward my health." "Very happy. Been with them five years so that says it all! They always ask if I am alright and can they do anything else before they leave, yes very caring and nice."

People said they felt comfortable with their care workers, and were treated as individuals. Staff knew people well; they had a good understanding of people's needs, choices, likes and dislikes. One staff member told us, "I love challenges. I am a people's person. What I do each day is about progressing and helping people. Caring for people we support and showing empathy and respect. Treating people as individuals."

People told us they were given choices on a daily basis for example, how they wanted their care to be given and what they wanted to eat or drink. One person told us, "Definitely! They listen to me and do whatever I want as it can change a little day to day, I have full control over my care with them and they respect my wishes."

Staff were given enough time to get to know people who were new to the service and read their care plans and risk assessments. Staff told us, although they knew what care people needed, they continually asked people what they wanted. People had allocated staff members who helped them achieve their goals, created opportunities for different activities and advocate on behalf of the person with their care plan.

People told us they were aware of the contents of their daily care files. These included contact information, their care plan and other daily monitoring forms pertinent to the individual. People and if necessary their relatives, were encouraged where possible to sign documents within their files which showed they were involved with the care they received. People told us they were given opportunities to make comments about the service and review their own care and support. Field care supervisors and the registered manager were involved in holding reviews with people and their relatives. This opportunity aimed to ensure people were happy with the care they received and any issues were dealt with effectively and promptly.

To ensure that all staff were aware of people's views and opinions, they were recorded in people's care plans, together with the things that were important to them. Without exception, staff told us that it was important to promote people's independence, to offer choices and to challenge people where needed help them achieve their goals. One person told us, "They [staff] encourage me to do things for myself despite having 24 hour care. I do try to stay independent as I like that and they will help me to do things myself." Another person told us, "They [staff] encourage me to walk and get around as I have a walking frame and stick and encourage me to take my own meds as well so I cope when they are not here." A third person told us, "Yes they [staff] make sure I use my walking aid to get around and always say 'come on you can do that you know you can' for different things in a lovely pleasant way."

Each person had a communication care plan, which gave staff practical information about how to support individual people who could not easily speak for themselves. The care plan gave guidance to staff about how to recognise how a person felt, such as when they were happy, sad, anxious, thirsty, angry or in pain and how staff should respond. People told us staff communicated with them in an appropriate manner according to their understanding.

Without exception every person we spoke to told us carers respected their privacy and dignity. Care plans contained guidance on supporting people with their care in a way that maintained their privacy and dignity and staff described how they put this into practice. All staff members we spoke with told us how they would draw people's curtains before supporting them with personal care. Staff we spoke with told us that it was important to ensure people had the privacy they needed and that they had their own space.

Good

Is the service responsive?

Our findings

Without exception every person we spoke to told us they were involved in decisions about their care and support and in reviewing their care needs. One person told us, "It's all very good. I get regular reviews so I know I am being looked after well."

People's needs had been assessed before they began using Caremark Norwich. People said the care plans reflected their support needs. The registered manager told us the assessments were carried out to ensure the service could provide the support people needed and they were used as the basis for the care plans. Care plans included a detailed assessment of people's needs and included people's preferences and routines. They had been completed with each person and their relatives where appropriate. Without exception, every person we spoke to told us that care workers knew their likes and preferences. Staff were able to provide examples of how they provided personalised care and support, which responded to people's needs.

Care plans were informative, comprehensive, and included people's religion, medical histories, social histories, health details and medical condition. Each care plan had additional policies, guidance and best practice documentation, which related specifically to the person's condition such as 'diabetes' guidelines. Daily care records reviewed showed that staff delivered the care each person required.

Care plans showed that people had been involved in their care planning. Reviews were completed where people's needs or preferences had changed and these were reflected in their records. This showed that people's comments were listened to and respected. One member of staff told us, "We always involve the person and their relatives if they want this." A relative told us, "The reviews are frequent and helpful. I feel fully involved and so does [person]."

No one we spoke with had experienced missed visits. Staff told us they felt supported by the office staff and by the information available in people's homes, which included the care plan, daily notes, protocols and guidance. Without exception people indicated they felt communication with the agency was respectful.

People were provided with a 'Service User Guide' which contained information about the provider, including the values and who to contact with any questions they might have. All of the people we spoke with confirmed they knew who to contact at the service if they had queries or changes to their care needs.

People knew how to make a complaint and felt that they were listened to. The procedure to make a complaint was clearly outlined in the complaints procedure and the 'Service User Guide', which had been sent out to all the people who used the service. There had been one formal complaint in the past 12 months. Records demonstrated this was listened to, investigated in a timely manner, and used to improve the service. Feedback from people was positive regarding the standard of care they received.

Requires Improvement

Is the service well-led?

Our findings

As referred to in the 'Safe' domain of this report, we received a mixed response regarding whether staff making care calls were on time and whether communication was effective between the office and people. This influenced whether people felt the office was Well-Led. Some people were frustrated with calls being later or earlier than they wanted and the lack of information provided from the office regarding rotas. One person said, "They [staff] have been up to one and half hour late. Only rarely do they call if going to be late." Another person told us, "They [staff] are mostly on time but sometimes late in the morning due to travel distance. This does worry me a bit but they do always get here eventually." Another person told us, "Now this is my only gripe. Since starting with them in March 2017, I have had 20 different carers, I keep a note." Another person informed us, 'I would like to be informed if there is a change as to who is coming. A weekly rota is supplied, but there are occasions when the rota says unallocated.'

In view of the feedback we received we recommend that the provider review and revisit how they share information with people and their relatives regarding limitations the service has regarding notice of who will be providing the support, if a visit is going to be delayed and what realistically can be offered and maintained. This is to ensure communication flow between the office and all people are open and to avoid further anxiety for those receiving care and support.

Audits were carried out by field care supervisors to ensure the quality of care provided to people. The registered manager told us, he would then read them to see if any additional action was needed. This included checks on people's daily completed records. These were carried out directly with people and their relatives in the community within their own homes. Whilst checking audit records we identified daily notes and MAR sheets were not being returned to the office by staff consistently. For example, one person's daily notes and MAR sheets had not been returned to the office for checking by management since 5 June 2017. Another person's records had not been brought to the office since 17 July 2017. We requested these records which were provided. We did not observe any negative impact on people due to the length of time noted and field care supervisors carried out routine checks on daily notes and MAR within people's homes. However, it may mean errors in medicine administration and/or injuries sustained, may go unnoticed by the office team and delay remedial actions. By the end of our inspection, the registered manager had discussed this with his office colleagues including the provider, to establish ways of how to improve the speed of how information was returned to the office for their review so any concerns did not get missed.

The provider's systems for monitoring quality and safety were not fully effective in addressing areas for improvement. There were monthly audits and these included care plans, staff files, medicines and training. However, where shortfalls were identified, there was a lack of detail regarding the action taken to address this and how it was followed up at the next audit to check it had been completed appropriately. For example, the daily notes were audited and the tool indicated that some errors had been made, but did not detail the nature of error and action taken. The provider was unable to show how they analysed and learnt from accidents and incidents. We found that the nature of accident and incidents that had occurred were not repeated ones and therefore found this had not impacted on people's safety. We found no evidence that the lack of audits and gaps in records had impacted on the quality of service people received. The absence

of detailed and recorded auditing meant the provider could not be assured of the quality of service delivered. The registered manager responded positively to our feedback and with the provider reviewed the auditing tool to ensure these areas would be improved. We will need to assess how this improvement has been embedded and sustained at our next inspection.

The registered manager was an active presence in the organisation and spent a lot of their time visiting the people they supported and providing clinical advice to staff. They were responsible for undertaking an initial assessment to decide if the organisation could support a person safely in a community setting. Staff told us his door was always open and we observed staff feeling comfortable enough to enter the office and talk with him when they needed to.

The staff team knew each other well and worked as part of a supportive team. A staff member said, "I like the support from management and the office. I have worked in care for nine years, but this company is really good. You have the support you need and the environment is friendly." Another staff member said, "I absolutely feel supported. I am adequately trained. We are part of a really good supportive team. I love working here."

There was an open and positive culture which gave staff confidence to question practice and report concerns. On a daily basis the staff had access to a secured online 'jotter' and 'pop up messages' from the care coordinators and field supervisors regarding any updates in policies / care plans that staff needed to be aware of. Each Monday the care coordinators and field supervisors met to review the previous week's information regarding people's health needs. We looked at the minutes from July 2017. Discussion included people's needs, safeguarding, policy and procedures, staff sickness, staff holiday, and professional conduct.

Monthly one to one meetings took place. This is when field supervisors meet with the person each month to discuss their views on the care they received. People were asked about the activities they would like to do in the future and discuss any changes occurring in the service, for example, staffing. This empowered people to contribute towards decision-making and make choices. One staff member said, "The objective of what we do is fulfilled. We meet the needs of individuals in supporting their personal needs, cooking, cleaning and emotional support."

The provider sought feedback from people through annual questionnaires to aid the strategic development of the service. These questionnaires had last been sent to people in April 2017 and the responses from people had been consistently positive.

The registered manager remained passionate about providing good care to people in their own homes. He was open throughout the inspection and remained proactive when addressing areas, which may require further improvement including sending the Commission documents to support any changes made. The registered manager also shared an office and worked alongside the company's recruitment administrator, and care coordinators who worked as a team to support people receiving care from the service.