Care Quality Commission

Trinity Healthcare Plus Limited

Rainbow Offices London

Inspection report

Unit 4 Rainbow Offices
10-12 Lumina Way
Enfield
Middlesex
EN1 1FS

Tel: 02034751919

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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

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to adults of all ages, including people with dementia or physical disabilities.

This was the first inspection of this service, which took place on 7 June 2018 and was announced. Not everyone using the service receives a regulated activity. The Care Quality Commission (CQC) only inspects the service being received by people provided with personal care, which is help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. At the start of our inspection there were 11 people using the service in this respect.

The service had a registered manager which 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.

At this inspection, there was positive feedback from people using the service, relatives and a community care professional. Everyone recommended the service.

The service had enough staff to meet people's needs. Staff were introduced to people at the start of a care package, and people consistently received the same team of staff.

The service and its staff treated people with kindness, respect and compassion, and gave emotional support when needed. People's privacy and dignity were respected and promoted.

People's needs were comprehensively assessed to help ensure their specific needs were identified and addressed. The registered manager demonstrated good knowledge of the wider community resources available in support of this. This meant the service worked well in co-operation with other organisations such as healthcare services to deliver effective care and support.

People were supported to have choice and control of their lives and staff supported them in the least restrictive way possible. People's views on the service were regularly sought and acted on, particularly through regular visits from managers who were also checking how well the service was meeting people's needs.

People's individual needs were met through the way the service was organised and delivered. This included helping some people regain skills and independence, and for providing compassionate and responsive end-of-life care to others.

The service took steps to assess and manage safety risks to people, and to protect them from abuse. Where

part of the agreed care package, it also supported people to eat and drink enough and to take prescribed medicines.

The service listened and responded to people's concerns and preferences, and used this to improve the quality of care.

The service promoted a positive and inclusive culture in support of achieving good outcomes for people. Staff reported being well-supported overall.

Systems at the service enabled sustainability and growth, and supported continuous learning and improvement.

We have made one recommendation in respect of staff recruitment practices. This was because we found concerns relating to how thorough the service's checks of staff members' Disclosure and Barring Scheme (DBS) disclosures were. These disclosures are checks of police records and a list of people legally recorded as unsafe to provide care to adults. The provider sent us supporting evidence shortly after our visit, to show they were taking robust actions to address these concerns This would prevent a reoccurrence of the same issues. The recommendation will help the provider to sustain appropriate standards.

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 consistently safe. Whilst recruitment checks of prospective staff were routinely carried out, the process was not always sufficiently comprehensive and timely.

The service assessed and managed risks to people, to balance their safety with their freedom. Systems, processes and practices safeguarded people from abuse and ensured that ongoing learning took place when things went wrong.

The service safely supported people to take prescribed medicines, and protected people by the prevention and control of infection.

There were sufficient numbers of suitable staff to support people to stay safe and meet their needs.

Is the service effective?

Good

The service was effective. People's needs were holistically assessed to help ensure the service was able to meet their specific needs. The service worked in co-operation with other organisations to deliver effective care and support.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support.

People were supported to eat and drink enough, maintain good health, and access appropriate healthcare services.

Consent was obtained before personal care was provided. Where anyone could not make that decision, the service was working towards assessment in line with the Mental Capacity Act 2005.

Is the service caring?

Good

The service was caring. It ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed.

People were supported to express their views and make their own decisions about their care and support. Their independence

was promoted.

The service ensured people's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive. It enabled people to receive personalised care that addressed their particular needs and preferences.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death.

Is the service well-led?

Good

The service was well-led. It promoted a positive and inclusive culture that achieved good outcomes for people. This included partnership working with other agencies to support care provision and development.

The provider's governance systems helped to identify and address risks to the health, safety and welfare of people who used the service.

Systems at the service enabled sustainability and supported continuous learning and improvement. People, their families and staff had opportunities to help develop 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 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 was an announced inspection that took place on 7 June 2018. We gave the provider 48 hours' notice of the inspection. This was because of the service's smaller size and we needed to be sure the registered manager would be available.

The provider completed a Provider Information Return (PIR) in advance of the inspection. 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.

Before the inspection, we checked notifications made to us by the provider, and information we held on our database about the service and provider.

The inspection was carried out by one adult social care inspector. There were 11 people receiving regulated activities from the service, and nine care staff, at the time of our inspection. During the inspection, we received feedback about the service from one person using it, the relatives and representatives of three other people, and one community health and social care professional. We also spoke with six staff members, the registered manager and the director of compliance and corporate affairs. During this report, any references to 'the management team' mean these latter two people.

During our visit to the office premises we looked at the care files of four people receiving a personal care service, the personnel files of four staff members, and other records relating to the care delivery and management of the service such as visit planning records. We were also provided with, on request, a copy of certain documents such as survey results and training certificates following our visit.

Requires Improvement

Is the service safe?

Our findings

The service routinely carried out recruitment checks of prospective staff such as by obtaining written references and checking identification and right to work in the UK. There were interview records to help consider whether the applicant held appropriate and safe values in respect to the job role. However, we found concerns relating to their checks of staff members' Disclosure and Barring Scheme (DBS) disclosures. These disclosures are checks of police records and a list of people legally recorded as unsafe to provide care to adults. Records showed that two staff who began employment in 2018 had started providing care to people in their own homes before the service had seen a DBS disclosure that indicated the person was safe to provide that care. The DBS disclosure for the third staff member was not at a level to include a check of whether they were barred from providing care to adults. The provider sent us supporting evidence shortly after our visit, to show they were taking robust actions to address these matters. This would prevent a reoccurrence of the same issues.

We recommend the provider seek training on safe and robust recruitment practices in the care industry.

The service's systems, processes and practices safeguarded people from abuse. The management team told us of having procedures in place, but that there had been no allegations of abuse relating to the service so far. Staff had been trained on what abuse could be and actions to take, and were provided with a copy of the provider's policy at the start of employment. Records showed safeguarding was discussed during staff meetings, with the registered manager recently dispensing knowledge from their attendance at a safeguarding session for managers hosted by a local authority.

The service assessed and managed risks to people, to balance their safety with their freedom. People and their representatives told us of no safety concerns in relation to their care visits. One person said their regular staff member "is more aware of safety than I am! She's very alert." A representative said, "They're very safe with hoisting, always two staff together." Another told us, "They're very conscious of safety; they raised issues with me as they were worried about this and that."

The service's initial assessments at the time of people starting care considered risks across a range of relevant areas. This included the care environment, the person's mobility and what support staff would be providing, the person's health needs, and their skin integrity. Community healthcare professional advice was also considered, such as occupational therapist guidelines on hoisting someone. Key aspects of the assessments were then highlighted within people's care plans to guide staff. This included, for example, on supporting someone to smoke safely, how to leave people's homes safely, ensuring people ate upright if in bed to minimise choking risk, and how to help different people mobilise or transfer safely.

The service ensured sufficient numbers of staff were available to support people to stay safe and meet their needs. One person told us, "You know when they're coming, and they arrive on time." People's representatives told us the service always supplied a staff member for planned visits. Comments included, "Their timekeeping is pretty good" and "There's been no punctuality concerns."

Staff spoke of receiving rosters in advance and having enough time in-between visits to get to people on time. The management team told us their current software enabled alerts to occur if staff had not logged their attendance at people's homes. This helped ensure people did not have a visit missed, although in practice staff were either running slightly late or forgot to log their arrival. Records showed staff staying the full length of time.

A staff member told us, "When we work in pairs, if one staff member doesn't turn up we can call the office and they will arrange for another staff member to attend." Another staff member said, "For 'double-ups', we meet up before going into the person's home. Everyone lives locally, so it works fine." The management team told us they provided care cover if ever it could not be managed within the local staff team. They showed us how staff shifts were planned manually, but explained this would shortly be through a dedicated software package.

The service ensured the proper and safe use of medicines where this was part of the agreed care package. A representative told us, "They encourage and remind her about medicines as she gets confused." A staff member told us of receiving medication training which "has given me a proper understanding of how drugs are being administered to clients."

Records showed people's needs in respect of medicines support were established at point of agreeing the service. Where possible, people signed consent for the specific support they were to receive. Their care plans then guided staff on the support to be provided and where to document this. We saw stand-alone medicines administration records (MAR) which staff signed when they supported people such as to open medicines bottles or when prompting the person to take prescribed medicines.

The service protected people by the prevention and control of infection. People and their representatives told us this was the case. Comments included, "No cleanliness concerns, they bring gloves and aprons." Records on staff files showed there was specific training and guidance for them on infection control standards. People's care plans provided guidance to staff on upholding infection control standards relative to the person's particular needs. This included use of personal protective equipment such as gloves and aprons. People's care records included reference to infection control support where appropriate.

The service learnt lessons and made improvements when things went wrong. There were two documented accidents and incidents since the service began operating. These showed good attention to the detail of what occurred. In both cases, the service and its staff had acted reasonably but other factors had caused the matters to occur. The service made sure further action took place, including through liaison with the person, their representatives and other community care professionals, to make sure changes were made to care packages or the person's circumstances. This helped minimise the risk of recurrence and helped keep the person safe.

Good

Is the service effective?

Our findings

The service assessed people's needs and choices so that care and support was delivered in line with standards to achieve effective outcomes. Someone using the service told us, "They're pretty good. I can't see in what way they could alter it." People's relatives and representatives told us they would recommend the service. Comments included, "They seem reasonable enough" and "They're very good and communicative."

Records showed the service usually received a community professional's assessment of care needs from which to make an initial judgement of whether the person's needs could be met. A member of the management team then visited the person and their representatives to assess their care needs and preferences. This took place where possible before care was agreed upon, but could be at the same time as starting care visits if, for example, people had short-notice hospital discharges. The service used a comprehensive needs assessment document for this process, from which a plan of care was developed. The process included use of a dependency tool that covered various aspects of the person's abilities. This enabled an easy means of documenting if the person's needs had changed over time, along with the views of the person and others involved.

The registered manager told us of one person initially assessed as needing two staff to help with mobility. However, a reassessment after a period of time recognised that they could manage to move themselves to an extent and so with a change of care objectives less care was agreed as needed. Another person had similarly reduced the number of times staff needed to visit. Conversely, examples were also given of where the needs assessment process established that more care than anticipated was needed, to help keep the person safe and alert.

The whole service worked in co-operation with other organisations to deliver effective care and support. Feedback from a community care professional indicated the service worked in collaboration with them and other professionals to meet someone's needs, particularly in relation to deteriorating health matters. The registered manager had good knowledge and experience of community resources and how to make sure the service successfully accessed them on behalf of people being provided with care. Records for one person newly using the service identified that they felt their bed was unsafe. This resulted in a referral to an occupational therapist. The registered manager told us bed-rails were provided in a matter of days, helping the person feel more secure. Records showed another person's needs assessment identified additional support needs. Liaison with the organisation funding their care enabled the service to provide longer care visits soon after the person started receiving care.

The service supported people to have access to healthcare services and receive ongoing healthcare support. We saw that needs assessments covered a range of practical health considerations, for example, swellings and other skin integrity matters, continence, allergies and breathing. This was in addition to the person's medical history. This enabled care to be planned to meet pertinent health needs. For example, one person's care plan provided staff with practical guidance on supporting them to manage a catheter.

People's care records provided updates on relevant health matters and any community professional visits. A

staff member told us the service's new online system for writing care records "helps flag alerts to the office just like that." They explained they used to phone the office if they had urgent health concerns about someone using the service, but the system now gave them confidence the agency was monitoring people's health needs more consistently and robustly.

The service supported people to eat and drink enough. People and their representatives were happy with the support to help with food and drink where agreed as part of the care package. Comments included, "They make him a cup of tea when I go out", "They microwave meals or make a sandwich" and "They help me with meals." People's care plans paid good attention to nutrition and hydration needs, for example, establishing who did what, what people preferred to eat, and reminding staff to document intake where assessed as needing monitoring. The registered manager told us of assessing one person's needs initially and finding they would benefit from more visits than anticipated. This was to help ensure they received enough support with eating and drinking in relation to associated health conditions they had.

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.

People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. Services providing domiciliary care are exempt from the Deprivation of Liberty Safeguards (DoLS) guidelines as care is provided within the person's own home. However, domiciliary care providers can apply for a 'judicial DoLS'. This is applied for through the Court of Protection with the support of the person's local authority care team. There were no people using the service that were subject to a judicial DoLS.

We found the service was working towards the principles of the MCA. Records of the initial meeting with people and their representatives include establishing if there was any form of formal delegation of authority from the person, such as a power of attorney. People signed, where possible, their consent to various aspects of their care. Records showed further consent was sought where changes in the care provided necessitated this, for example, after someone agreed to allow staff to use a key-safe for entry into their home.

The service assessed people's capacity to consent to their care. However, where the initial two-stage test established there was no impairment or disturbance of the person's functioning of mind or brain, the service incorrectly continued to assess the person's capacity to make the decision despite there being no need for this. We explained this to the registered manager.

People's care records indicated where they refused aspects of care at specific times. This helped show consent was sought in practice and that people's decisions were respected. Records showed staff were trained on the relevant principles of the MCA in relation to their care work. This occurred at their induction and within staff meetings and supervisions.

The service made sure staff had the skills, knowledge and experience to deliver effective care and support. People and their representatives told us this was the case. Comments included, "Staff seem capable" and "The ladies are very good." A community care professional told us of skilled staff at this service.

Staff told us of good support to develop skills for their care roles. Comments included, "Training is good and

not complicated", "They give us support with practical training" and "With training programmes being organised online for staff members, staff members are being refreshed on new ways of helping our clients."

The registered manager told us they directly trained new staff in the office on the main principles of care. They showed us qualifications for undertaking this. Staff files showed that this process covered a range of topics including, for example, personal and catheter care, meal preparation, safeguarding, and health and safety matters.

New staff then shadowed experienced staff providing care in people's homes. This took up to ten hours, from which there was a record of competencies observed. The registered manager oversaw this, and asked the new staff member questions to make sure they understood their role.

Records showed staff received quarterly developmental supervision meetings. These were tailored to the individual staff member's role and needs, and so covered, for example, approaches for gaining consent to care, safe use of key-safes, and potential signs of abuse. Plans were in place for annual staff appraisals but no staff had completed a year's worth of work at the time of the inspection. There were also quarterly staff meetings in support of the development of staff.

Good

Is the service caring?

Our findings

The service ensured that people were treated with kindness, respect and compassion, and that they were given emotional support when needed. People and their representatives praised how caring the staff were. Comments included, "They seem very kind", "They're really caring, they sit and chat with him" and "When they're done, they ask, 'Is there anything else you'd like me to do?'" A community care professional told us of compassionate care staff. We also saw written compliments at the service's office from relatives of people who used the service praising the caring nature of the service and its staff.

The service's initial needs assessments included consideration of people's emotional wellbeing. Care plans were set up from this, which helped care staff to provide individualised support in this area when needed. Staff also informed us of the caring approach of the service. One staff member said, "The whole service is centred around our clients and it shows. Our job is very rewarding because of the positive impact we have." Another staff member told us of "holding the hand" of someone who felt restless. The registered manager told us of one staff member bringing someone a plant on Valentine's Day in the absence of the person's spouse. The staff member knew the plant was closely associated with the spouse. They also told us staff sometimes bought essential shopping like bread and milk on their way to people's care visits.

One person's representative told us of the registered manager visiting to introduce a staff member who would provide regular care. The registered manager told us they usually introduced the primary staff member to new people at the first visit. Staffing rosters and people's care records showed people received the same staff member or small team of staff most of the time. People and their representatives confirmed this was the case, for example, "It's always the same two staff" and "It's the same staff as much as possible." The registered manager told us the service's minimum visit time of 45 minutes meant people were not rushed. All of these processes enabled companionship and trust to develop.

The registered manager said staff were recruited primarily on their values, on how they could demonstrate a caring nature such as by being willing to stay a bit longer at care visits or knowing how to pick up people's spirits. The management team recorded checks of staff members' individual approaches at people's homes. These are known as 'spot-checks.' They included checks of how caring the staff member was and whether they showed interest in the person's wellbeing. The management team told us they also checked on how caring the service was through feedback forms that people and their representatives returned, and through phone calls and monthly visits to them.

The service ensured people's privacy and dignity was respected. People and their representatives told us this was the case. Their comments included, "They do what we ask", "They let me know if there's changes" and "If they're running late, they inform us." We saw interview records on staff files that included a question on dignity. Staff told us of training on dignity, and gave examples such as covering people where possible when washing them and closing doors for personal care.

As far as possible, the service supported people to express their views and be actively involved in making decisions about their care and support. People and their representatives told us the service checked on their

views to help set up the care package. Comments included, "They checked the times that suited and have stuck to them." Needs assessment records included the views of the person starting to use the service or their representative. A care plan was drawn up arising from the needs assessment, which the person was duly asked to sign agreement to where possible.

The registered manager told us of visiting most people weekly, to help ensure their views and those of their representatives where appropriate were sought, along with checking on the care being provided. This included using the service's laptop to engage in a real-time video conversation with one person's family in another country. People's files included surveys sent by the management team to check on their views. These included checks on whether the person felt involved in their care plan.

The service ensured people's independence was promoted. People and their representatives told us this was the case. One person said, "We manage together. I said to [the care staff member] today, 'I ought to manage by myself more'; she said, 'it's up to you.'" They explained the staff member then provided options.

People's care records showed support was provided where needed but that people were enabled to be independent where possible, both in terms of choices and actions. People's care plans reminded staff on what the person could manage themselves and the level of support needing to be provided.

Staff told us of helping people regain skills. One staff member told us of a person hardly interacting when starting to provide care, but "now he interacts all the time and he's lifting himself." They explained that the person's improved skills meant they no longer needed so many care visits.

The registered manager told us of the service helping people to regain independence. They cited agreeing small but achievable weekly goals with the person. In time this meant less visits or cessation of the service as people no longer needed the support. However, some people continued with the service due to valuing the companionship.

Good

Is the service responsive?

Our findings

The service enabled people to receive personalised care that was responsive to their needs. People's care plans guided staff on how to support their particular needs and preferences in relation to the services being provided. For example, one person's care plan informed staff exactly how to support them to manage their medicines. Another person's guided staff on the person's preferred morning routine and how to work in co-operation with that. Care plans included whether the person's culture and religion impacted on the proposed service, which people and their relatives confirmed was checked on. They also covered, for example, how to work with the person's emotional needs, their particular physical health needs, infection control matters, mobility support, and circumstances where people were more willing to consent to care.

A staff member told us the consistent and responsive care provided to one person had helped improve the quality of their life. At the start of the care package, the person "declined everything." However, through the service's "encouragement and persistence", the person "now lives a healthier, more fulfilled life." The staff member cited the person's skin condition now being well managed, the person now attending appointments, and the person no longer expressing anger with their situation. The staff member added that because staff now knew the person well, "We can pick up if something is wrong and act quickly to make it right." The feedback matched records on the person's file which showed the progression they had made since starting to use the service.

A staff member told us, "The registered manager tries to come once a week to everyone receiving care, and meets us where needed." The registered manager told us of informally reviewing people's care needs most months, in conjunction with the person and involved others. We saw examples of how care plans had been updated as a result of changes in people's circumstances. However, the meetings were only briefly written up in people's ongoing care visit records, which did not help to clarify and highlight the salient points of the discussions. The registered manager agreed to set up stand-alone documents about these meetings.

The service supported the communication needs of people with a disability or sensory impairment. One person's representative told us, "They try to communicate with her, it's not easy, but she has improved dramatically in the last few days which might be because of their care." The management team told us of developing communication cards of key items and phrases for one person which the person pointed at. The cards were left with the person's family too, helping them communicate with the person more. Additionally, the regular staff found the person used their eyes to direct them.

Needs assessments included people's communication abilities, so that care plans could guide staff on more effective interactions. For example, one person was noted to speak slowly and softly, so staff needed to be quiet and patient to enable effective communication. Staff needed to speak to the right side of another person due to a hearing impairment.

The service supported people at the end of their life to have a comfortable, dignified and pain-free death. A community care professional told us the service worked well with them to meet to meet the needs of someone receiving end-of-life care. We also saw a written compliment from a relative praising staff for their

alertness in noticing and responding their family member's health deterioration. This was despite them only using the service for a few days.

The registered manager demonstrated pertinent knowledge of end-of-life care matters, for example, that people's families often needed support and guidance. They told us they trained staff on end-of-life care using their experience, supported by an online course. We saw completion certificates for the online training. They also told us of some staff shadowing clinical specialists to improve their knowledge, and of supporting people and staff through weekly visits to those receiving end-of-life care.

Staff told us of supporting people with end-of-life needs. One staff member said, "My care has made them very comfortable in their final stages. Also, I'm able to support their families as it's so hard for them that they can't cope." Another told us of their "heart-break" on finding people they had cared for had passed away. A third said, "It's most important to make them feel comfortable with you, to be their friendliest person in the world." They told us of end-of life training themes but noted that each person needed individualised care.

The service set up specific end-of-life care plans that focussed on likely needs of the person such as communication, pain management, skin and mouth care, liaison with other community care professionals, and preferences around death. The registered manager gave examples of different approaches people wanted to their care at the time of their death, ranging from not wanting it discussed through to ensuring cultural and religious customs were followed and relevant people contacted. They told us joint working with palliative nurses tended to help people discuss these matters.

The service listened and responded to people's concerns and complaints, and used this to improve the quality of care. People and their representatives told us of being informed how to complain but of not needing to. One person said, "I've got their phone number if needed." Staff told us of informing the registered manager if a complaint was raised about the care service. Staff meeting minutes showed that the management team provided reminders on how to handle concerns or complaints openly.

The management team told us of having a complaints system that they informed people of. However, as they checked up on people's services regularly, which enabled any concerns to be quickly addressed, there had been no formal complaints so far. They gave examples of where they had addresses minor matters. One person told them they were happy with their staff member but sensed the staff member was uncomfortable handling food that they wouldn't usually handle due to their religion. The management team checked this with the staff member, and decided to move them to visits to that person that did not involve food handling.

Good

Is the service well-led?

Our findings

The service had a registered manager who was also a director of the company. They demonstrated good knowledge of people's individual needs. They held appropriate management and care qualifications, including retaining a nursing qualification. They described many years' experience of working in the care sector, primarily as a community nurse. They said the way the service worked was based on this experience along with responding to the ongoing findings of operating this care service.

There was much praise of the management approach of the service. Comments from people and their representatives included, "It seems well-managed", "They're very knowledgeable" and "The managers seem approachable." A community care professional told us of the registered manager checking that staff were providing good care. We also saw a written compliment from a relative praising the positive and professional approach of the management team. This helped assure us that the service promoted a positive and inclusive culture that achieved good outcomes for people.

Systems at the service enabled sustainability and supported continuous learning and improvement. The management team told us of gradual expansion of the service in line with available resources. For example, they were now providing services in two geographical areas and to more people than at the start of the year, following many applications and visits to care funding organisations to demonstrate their services. The regular supply of work from one area plus recognition of staff turnover if hours could not be regularly supplied meant the company was now advertising to recruit staff on part-time rather than industry standard zero-hours contracts. The management team explained this would give staff reassurance of a regular wage and should enable better staff retention.

The service had also moved to a larger office that was more central to the two areas where people were using services. They had purchased and started using online care planning and documentation systems that staff used where possible at their care visits. Further upgrades were now taking place, including live monitoring of staff attendance at planned visits.

The management team told us of meeting most weeks to review important aspects of the service. Minutes of these meeting produced actions for further development or to mitigate service delivery risks, for example, on staff training and development, staff recruitment and retention, and the particular needs of some people using the service.

Staff told us of good support from an approachable management team. One staff member said, "You're never in it alone, you can always get one of the managers and if they don't have the answer they will get back to you promptly." Another told us, "The company is very supportive and are always on the other end of the phone if we need them." All staff said they would recommend the service to friends and family needing care.

The provider engaged with and involved stakeholders in the development of the service. The management team told us of phoning and visiting people to check on the quality of their services. People and their

representatives confirmed this occurred. This was tailored to how often people wanted contact, as for example, one person told them not to visit as the person would contact them when needed.

We saw feedback forms from people using the service and their representatives. These were analysed monthly. Feedback was predominantly positive, which helped assure the provider that good quality care was being provided. However, the process also enabled responses to be made if concerns were raised. The analysis included 'corrective actions' statements where anyone's feedback was not entirely positive.

The management team also distributed a survey to staff this year, by which to consider how supported staff collectively felt. Results showed positive feedback but the management team recognised areas for improvement such as with feeling isolated. They made plans on how to help staff feel more involved and connected, including enabling more joint visits to people using the service and different ways of engaging through technology.

The provider's governance framework helped to ensure quality performance, risks and regulatory requirements were understood and managed. The management team told us of undertaking spot-checks of each staff member on a six-weekly basis. These are unannounced visits to people's homes to check the staff arrived on time and did the job well. Records in staff files showed that these occurred, and care staff also confirmed they took place. An oversight matrix informed us the six-weekly frequency was being maintained, which helped to demonstrate regular checks of individual staff approaches.

A documented review of the service took place at the start of the year, based on surveys results, feedback from multidisciplinary teams and referral sources, spot-checks and team meetings. This appraised a number of aspects of the service, to check what was working well and what could be improved on. These reviews were planned to occur twice a year.

The service worked in partnership with other agencies to support care provision and development. The management team showed us records of attending relevant care forums and reading best practice guidance, to help develop their service. They were members of a care providers' association in one of the areas they provided care to people in, which they told us enabled networking, training and shadowing opportunities. We also saw records of the registered manager being supervised by an independent professional, to help ensure theirs and the service's development.