Mears Care Limited

Mears Care - Ashford

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?	Outstanding
Is the service responsive?	Good
Is the service well-led?	Good

Overall summary

The inspection was carried out on 03 March 2015, and was an announced inspection. The manager was given 48 hours' notice of the inspection as we needed to be sure that the office was open and staff would be available to speak with us.

Mears Care - Ashford is a domiciliary care agency which provides personal care and support for older people and younger adults who are living in their own homes. At the time of the inspection, the service was providing support to 83 people, in the areas of Ashford, Tenterden, Brabourne, Charing, Chilham, Challock and surrounding areas. Most people were funding their own care through direct payments. Some people were funded through NHS continuing care services.

The service is run by a registered manager, who was present throughout the day of the inspection visit. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like

Summary of findings

registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act and associated Regulations about how the service is run.

The Care Quality Commission is required by law to monitor the operation of the Deprivation of Liberty Safeguards. The manager and staff showed that they understood their responsibilities under the Mental Capacity Act 2005.

The agency had suitable processes in place to safeguard people from different forms of abuse. Staff had been trained in safeguarding people and in the agency's whistleblowing policy. They were confident that they could raise any matters of concern with the registered manager, the director, or the local authority safeguarding team. Staff were trained in how to respond in an emergency (such as a fire, or if the person collapsed) to protect people from harm.

The agency provided sufficient numbers of staff to meet people's needs and provide a flexible service. Staff were able to accommodate last minute changes due to people's appointments or other staff sickness. Staff were allocated to people within a close range of each other, so that they would not have long distances to travel between attending to people. This ensured that they would not be delayed from attending to people at the correct appointment times.

The agency had robust recruitment practices in place. Applicants were assessed as suitable for their job roles, and new staff were provided with a detailed induction programme, which included training in essential subjects. Refresher training was provided at regular intervals. No staff commenced any duties until a satisfactory Disclosure and Barring Service (DBS) check had been received. (DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people).

All staff received induction training which included essential subjects such as maintaining confidentiality, moving and handling, safeguarding adults and infection control. They carried out shadow shifts and had their competency assessed before they were allowed to work on their own. The registered manager ensured that staff had the right training and experience to support people with specific needs, such as dementia care, or end of life care. Other staff training included assisting people with managing their medicines. Some calls were specifically to visit people to prompt them to take their medicines, or to check they had taken them.

The senior agency staff (known as 'visiting officers') carried out extensive risk assessments when they visited people for the first time. This was to assess that the home was safe for providing their care, and for staff's safety. Other assessments identified people's specific health and care needs, their mental health, medicines management, and any equipment needed. A care plan was drawn up and agreed between the agency and the individual people concerned. Some people were supported by their family members to discuss their care needs, if this was their choice to do so.

People were supported with meal planning, preparation and eating and drinking. Staff also supported people by contacting the office to alert the manager to any identified health needs so that their doctor or nurse could be informed.

People all spoke positively about their care staff and had no negative comments about their work. They gave examples of how care staff went beyond their required duties, and offered to do extra things. People said that they knew they could contact the registered manager or their visiting officer at any time. The visiting officers carried out frequent spot checks to assess care staff's work and procedures, with people's prior agreement. This enabled people to get to know the visiting officer so that they felt confident about raising any concerns or other issues.

The agency had processes in place to monitor the delivery of the service. As well as talking to visiting officers at spot checks, people could phone the office staff at any time, or speak to the senior person on duty for out of hours calls. Care plan reviews were carried out with people after 28 days, and then every six months, or sooner if needed. Changes were made to their care plans as they were needed. People's views were also obtained through annual surveys. These could be completed anonymously if people wished. The agency's head office analysed these and checked how well people felt the agency was meeting their needs.

The registered manager sent out monthly newsletters to staff to keep them informed about events, changes, ideas,

Summary of findings

training dates and meetings. The agency staff provided events together for the benefit of people receiving support. These had included a full Christmas dinner and entertainment in 2014, as well as a Summer Fair, and a Macmillan coffee morning. This was an innovative way to assist people to feel included as part of the agency, and to give people a focus and prevent loneliness. Staff also provided items to put into Christmas hampers for people who did not have anyone else to support them or care for them, showing that their care and compassion extended beyond their own job roles.

Summary of 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?

Good

The service was safe. Agency staff were informed about safeguarding adult procedures, and took appropriate action to keep people safe.

The agency carried out environmental risk assessments in each person's home, and individual risk assessments to protect people from harm or injury. Accidents and incidents were monitored to identify any specific risks, and how to minimise these.

Staffing levels were maintained at a satisfactory level to provide people with the service they needed. The agency had robust recruitment procedures in place.

Is the service effective?

Good

The service was effective. Staff received on-going training and supervision, and studied for formal qualifications.

Staff knew how to apply the Mental Capacity Act 2005, and were able to assess if people were able to make day to day decisions in line with their level of capacity.

Staff supported people with their nutrition and assisted them with eating and drinking. They were knowledgeable about people's health needs, and contacted other professionals if they had concerns about people's health.

Is the service caring?

Outstanding

The service was caring. People felt that staff went beyond their call of duty to provide them with good quality care. The agency staff kept people informed of any changes relevant to their care needs.

Staff protected people's privacy and dignity, and encouraged them to retain their independence where possible.

Staff gave their own time and resources to provide people with special events during the year, so that people had extra events for their enjoyment.

Is the service responsive?

Good

The service was responsive. People's care plans reflected their care needs and were updated in line with care reviews.

Visit times were discussed and agreed with people. Care plans contained details of the exact requirements for each visit.

People felt comfortable in raising any concerns or complaints and knew these would be taken seriously. Action was taken to investigate and address any issues.

Is the service well-led?

Good

The service was well-led. The registered manager led the way in encouraging staff to take part in decision-making and continual improvements of the agency.

Summary of findings

The registered manager maintained quality assurance and monitoring procedures in order to provide an on-going assessment of how the agency was functioning; and to act on the results to bring about improved services.

Mears Care - Ashford

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 was 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.

The inspection took place on 03 March 2015 and was announced. The manager was given 48 hours' notice of the inspection as we needed to be sure that the office was open and staff would be available to speak with us. The inspection was carried out by one inspector and an expert by experience. An expert by experience is a person who has personal experience of caring for someone who uses this type of care service, and the expert was experienced in older people's care.

We looked at previous inspection reports and notifications received by the Care Quality Commission (CQC). A notification is information about important events which the service is required to send us by law. We obtained information from six health and social care professionals before the inspection, about the care given to their clients. We spoke to nine people who received support in their own homes; and obtained feedback through the use of questionnaires.

We visited the agency's office, which was situated in the town centre of Ashford.

During the inspection visit, we reviewed a variety of documents. These included four people's care plans and daily records; three staff recruitment files; staff induction and training programmes; staffing allocations; medicine administration records; health and safety and environmental risk assessments for people in their own homes; records of accidents and incidents; the complaints file; quality assurance questionnaires; newsletters; and some of the agency's policies and procedures.

The previous inspection was carried out in November 2013, and there were no breaches of the regulations. The service had moved offices within the same premises since then, and this had entailed new registration procedures for a move of their location. The agency had carried out appropriate registration changes with the Care Quality Commission.

Good

Is the service safe?

Our findings

People said they felt safe using this agency. Everyone spoken with said that they felt safe with their care staff and had no cause for concern regarding their safety or the manner in which they were treated by care staff. A relative wrote in a questionnaire, "Mears have stepped in and have been brilliant at keeping us informed, and have done everything possible to keep Mum safe."

Social care professionals told us "I have always found Mears Care to be very helpful and the staff are very good at reporting any concerns or issues." And, "I have always found staff to be both helpful and professional, my clients have always spoken highly of them. They have also responded very quickly to any questions or queries that I have".

Staff had been trained in how to safeguard adults from harm or abuse. They understood the different types of abuse and how to recognise potential signs of abuse. This training was commenced at induction, and there was on-going refresher training. The agency's policies and procedures were included in a staff handbook which staff could carry with them. This provided them with contact information in the event of any concerns of abuse. Staff said they would usually contact the registered manager or office staff immediately if abuse was suspected, but knew they could also contact the Social Services safeguarding team directly.

The agency had processes in place to protect people from financial abuse. This included recording the amount of money given to care staff for shopping; providing a receipt; and recording the amount of change given. Where possible, this transaction was signed by the staff member and the person receiving support, or their representative.
The visiting officer provided people with a prices list at the first meeting together, and a contract was agreed and signed by both parties. This ensured that people who were paying with direct payments were fully informed and in agreement with the costs of their care. Agency staff were not permitted to receive gifts or be named in legacies, as a precaution against financial abuse.

Before any care package was commenced, the registered manager or visiting officer carried out risk assessments for the environment, and for the care and health needs of the person concerned. Environmental risk assessments were very thorough, and included risks inside and outside the home. For example, they noted when entry may be through a side gate that did not have a light, and stated that care staff should carry a torch with them if the call was in the evening or early morning. The risk assessments also noted if there were steps to the property which could be slippery in wet or icy weather. Risk assessments for inside the property highlighted if there were loose rugs or mats that could be a slip or trip hazard; if there were obstacles in corridors; and if there were pets in the property. They included checks for gas and electrical appliances, safe storage of cleaning materials, and the location of mains services.

Risk assessments included information about action to be taken to minimise the chance of harm occurring. For example, some people had restricted mobility and information was provided to staff about how to support them when moving around their home and transferring them in and out of their bed or to a wheelchair. People were provided with equipment to support them such as bed rails to prevent falls from bed; mobile or ceiling hoist facilities; pressure-relieving mattresses and cushions; and commode shower chairs. Exact instructions were given about how to use individual hoists, and how to position the sling for the comfort of the person receiving support. People who required hoisting to help them move from one place to another were always supported by two care staff working together. Equipment was provided through the services of occupational therapists or district nurses, who ensured that people had the right equipment, and that care staff were provided with the information they needed to use it correctly.

The staff ensured that required checks and servicing were carried out for lifting equipment and that hoists were kept on charge when not in use. Each person had a fire action plan in place in the event of an emergency. Some people were provided with a pendant 'lifeline' which could be worn around their necks, and enabled them to press the alarm if they had an accident or were seriously unwell. (These are a 24 hour care system to alert on-call operators to obtain help for people). Care staff checked that people had their lifeline pendants in place before leaving the premises.

Care staff knew how to inform the office of any accidents or incidents. They contacted their visiting officer, and completed an incident form after dealing with the

Good

Is the service safe?

situation. The registered manager viewed all accident and incident forms, so that she could assess if there were any patterns of behaviour, and if there was any action that could be taken to prevent further occurrences.

There were sufficient numbers of care staff available to keep people safe. Staffing levels were determined by the number of people using the service and their needs. Staffing levels could be adjusted according to the needs of people, and the number of staff supporting a person could be increased if required. Care staff were allocated to support people who lived near to their own locality. This reduced their travelling time, and minimised the chances of staff being late for visit times. The registered manager had implemented changes in response to concerns that staff were sometimes arriving a few minutes late. In response to this, an extra five minutes was being allocated at the end and start of each new call, so that this allowed for the time needed to travel between calls.

The agency had robust staff recruitment practices, ensuring that staff were suitable to work with people in their own homes. These included checking prospective employees' references, and carrying out Disclosure and Barring Service (DBS) checks before successful recruitment was confirmed. (DBS checks identify if prospective staff have had a criminal record or have been barred from working with children or vulnerable people). Employment procedures were carried out in accordance with equal opportunities. Interview records were maintained, and applicants were provided with a job description. Successful applicants were provided with the terms and conditions of employment, and a copy of key policies, such as maintaining confidentiality, security of people's homes, emergency procedures and safeguarding.

Care staff were trained to assist people with their medicines where this was needed. Checks were carried out to ensure that medicines were stored appropriately, and care staff signed medicines administration records for any item where they assisted people. We saw that records had been accurately completed. Care staff were informed about action to take if people refused to take their medicines, or if there were any errors. Some visits were allocated for just 15 minutes. These were solely to check that people had taken their medicines, or to prompt them to do so.

Good

Is the service effective?

Our findings

People said that they thought the staff were well-trained and attentive to their needs. Feedback from people was very positive, and comments included, “We greatly appreciate the quality of care provision”; and “We are very grateful to staff for all their dedication.” Social care professionals told us, “I have confidence in Mears staff providing a high quality of care to the vulnerable community. The care staff went above and beyond their remit in order to support some very vulnerable people. In one client’s case I truly believe it was mainly as a result of Mears support that they remained at home as long as they did.” And, “I have always found Mears staff to be both helpful and professional, my clients have always spoken highly of them”.

Staff completed an induction course that was in line with the nationally recognised ‘Skills for Care’ common induction standards. (These are the standards people working in adult social care need to meet before they can safely work unsupervised). All care staff were required to study for a formal qualification such as a diploma or Quality Credit Framework (QCF) to a minimum of level 2 in health and social care after completing their probationary period. These qualifications build on the common induction standards and are nationally recognised qualifications which demonstrate staff’s competence in health and social care. At the time of our inspection, 90% of care staff had trained to this standard. Visiting officers had trained to level 3, or were in the process of completing this training.

The induction and refresher training included all essential training, such as moving and handling, fire safety, safeguarding, first aid, infection control and applying the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards. Staff were given other relevant training, such as managing catheter care, safe handling of medicines, and dementia care. The registered manager had recognised that care staff would benefit from more advanced training in dementia care, and this was being arranged. The agency offices included a training room where face to face training was carried out. This enabled staff to discuss their training together, and develop a greater understanding of their roles.

Staff were supported through individual supervision with their visiting officers, and the registered manager had commenced yearly appraisals for all staff. Visiting officers carried out spot checks of care staff in people’s homes. A spot check is an observation of staff performance carried out at random. These were discussed with people receiving support at the commencement of their care package, so that they had already expressed their agreement to visiting officers carrying out staff checks while they were receiving care and support. People thought it was good to see that the care staff had regular checks, as this gave them confidence that care staff were doing things properly. Spot checks were recorded and discussed, so that care staff could learn from any mistakes, and receive encouragement for their work. We saw the records for a spot check where a staff member had been assisting someone with their lunch. The report showed that they had checked with the person for their choice of meal; wore personal protective clothing and washed their hands before food preparation; checked that food items were in date; gave the person a fresh drink of their choice; and encouraged them to be independent with their eating and drinking. The visiting officer commended them for their punctuality, smart appearance, wearing their uniform and identity badge, carrying out the care correctly, and speaking in a kind and caring manner to the person.

Staff were trained in the Mental Capacity Act 2005 and the Deprivation of Liberty Safeguards (DoLS). Staff understood the processes to follow if they felt a person’s normal freedoms and rights were being significantly restricted. Visiting officers carried out a mental capacity assessment at the first visit, to determine people’s ability to understand their care needs and to consent to their support. When people lacked mental capacity or the ability to sign agreements, a family member or representative signed on their behalf. The registered manager met with family members and health and social care professionals to discuss any situations where complex decisions were required for people who lacked capacity, so that a decision could be taken together in their best interests.

Staff were matched to the people they were supporting as far as possible, so that they could relate well to each other, and lived fairly near. The visiting officers introduced care staff to people, and explained that they were allocated with a minimum of four care staff. This meant that people could get to know the same care staff who would be supporting them, and allowed for consistency of staffing, and cover from staff that people knew in the event of staff leave or sickness.

Good

Is the service effective?

Care staff supported people with their nutritional needs, which included carrying out food shopping, meal preparation, and assisting people to eat and drink. When people were at risk of poor nutrition, the care staff completed records of the food and drink taken, and alerted the office staff if they had concerns. Daily records showed details such as 'Ate all their lunch' with information about the food given; and 'Drink given in thermos cup with straw', and 'Beaker of water provided'.

Care staff identified any concerns about people's health to the office staff, who then contacted their GP, community nurse, mental health team or other health professionals. Each person had a record of their medical history in their care plan, and details of their health needs. Records showed that agency staff worked closely with health professionals such as district nurses in regards to people's care. This included pressure relief, applying skin creams, recognising breathing difficulties, pain relief, catheter care and mental health concerns. For example, care staff informed the office if a person's catheter had not drained much urine and may be blocked; or if someone had a mark on their skin where a pressure sore may be developing. Occupational therapists and physiotherapists were contacted if there were concerns about the type of equipment in use, or if people needed a change of equipment due to changes in their mobility.

Outstanding ☆

Is the service caring?

Our findings

People said that staff "Went beyond" their expectations, were highly motivated, and gave them good or excellent quality care. People's comments included, "All your staff are friendly", "I like having the same carer and no changes", "The carers are very pleasant", and "I love these people. I can always have a laugh with them while they are helping me". Another person said, "All the carers I have had are very helpful and kind. They are wonderful". One person described the care staff as "Very accommodating". Others gave examples of how care staff asked them if there was anything extra they could do. One person told us that the care staff would occasionally collect fish and chips for them on Fridays so that they could continue to enjoy their favourite food despite being housebound. People said that the care staff were "Thoughtful", and showed empathy and understanding of them. No-one had anything but praise for the care staff.

The agency's questionnaire responses from 2014 supported this. People had been asked if they were overall satisfied with the service, very satisfied, extremely satisfied, neither satisfied or dissatisfied, or not satisfied. Out of 35 responses, 27 people had stated they were extremely satisfied or very satisfied, and the remainder were all satisfied. Thank you cards expressed people's satisfaction with their care, such as, "I want to let you know how amazing your staff are. Our relative could not have had better care and your staff were truly exceptional."

Social workers all gave us positive feedback. Their comments included, "The care staff went above and beyond their remit in order to support some very vulnerable people"; and "I have always found Mears to be very supportive, helpful and reliable. They communicate any issues promptly and respond swiftly. Clients who have been in receipt of their care both past and present have always spoken well of the care they have received".

The agency had reliable procedures in place to keep people informed of any changes, and the registered manager told us that communication with people and their relatives, staff, health and social care professionals was a key for them in providing good care. All telephone calls were logged on to a computer system, and where action was needed in response to a phone call, this was carried out promptly. People were informed if care staff were delayed and would be late for a call, or if they were off sick, and which care staff would replace them. We heard office staff making preparations for care staff to cover another member of care staff when they were going on leave, and people were informed of who would be going in to provide their care.

People were informed of agency processes during their first visit. The visiting officer provided them with a copy of the agency's statement of purpose and service users' guide. They encouraged people to phone the agency at any time, and informed them there was a senior staff member on call out of hours to deal with any issues of concern. There was a continual striving to provide people with compassionate care, and people said that they did not have any concerns.

People said that staff were respectful of their privacy and maintained their dignity. Staff gave people privacy whilst they supported them with personal care, but ensured they were nearby to maintain the person's safety, for example if they were at risk of falls. One person said, "I am very grateful for all their dedication, and they see to all the things I cannot do for myself."

The agency provided personal touches for people, such as sending each person a birthday card and Christmas card. Staff donated items together to give Christmas hampers to people who did not have anyone else to care for them. One care staff had made all the clients a small Christmas cake. In December 2014 the agency staff had all worked together to provide people with a full Christmas dinner and afternoon's entertainment in a local community centre, and had brought in an entertainer to sing for them. People thought this was wonderful, and it enabled them to meet other people, and took away loneliness at Christmas for some people. One relative had written afterwards, "All of you worked so hard to deliver an excellent meal and entertainment. I know my mother really enjoyed herself".

The agency organised other events for people's enjoyment, such as a Summer fair, with stalls such as a cake stall, plant stall and book stall. People's friends and relatives had been invited to take part. On another occasion they had provided a 'Falls Awareness' event, when all the attendees were given a free pair of slippers. This demonstrated the agency staff's dedication in giving their own time and resources to put on extra events for the benefit of people receiving care and support.

Good

Is the service responsive?

Our findings

People described their care staff as being adaptable and trying to fulfil their needs, and "Never felt the need to complain". Staff were informed about the people they supported as the care plans contained information about their backgrounds, family life, previous occupation, preferences, hobbies and interests. The plans included details of people's religious and cultural needs, so as to ensure that the care staff allocated to them would be suitable for them.

People were asked how they felt about the necessity of receiving support at home, so that it gave insight into their mental state and their receipt of care. For example, one care plan stated the person's response was 'Happy for care staff to come'; and another had recorded, 'I like to see the care staff'. Visiting officers discussed the length and time of visits that people required, and these were identified in their care plans. Each visit had clear details in place for exactly what care staff should carry out at that visit. This might include care tasks such as washing and dressing, helping people to shower, preparing breakfast or lunch, giving drinks, turning people in bed or assisting with medicines. The visit may also include domestic tasks such as doing the shopping, changing bed linen, putting laundry in the washing machine and cleaning.

Visits showed if one or two care staff were allocated to the person, and itemised each task in order, with people's exact requirements. This was particularly helpful for care staff assisting new people, or for care staff covering for others while on leave, when they knew the person less well than other people they supported, although they had been introduced. Spot check reports showed that people felt secure in knowing that visiting officers were assessing care staff for how well they carried out their duties, and that this helped staff to develop their skills and their knowledge. Spot check reports identified when care staff might be able to carry out a task more efficiently, as well as encouraging staff when they demonstrated good care practices.

Visiting officers carried out care reviews with people after the first 28 days of receiving care, and then at six-monthly intervals. Any changes were agreed together, and the care plans were updated to reflect the changes. Care staff who provided care for the person were informed immediately of any changes. Care plans were also reviewed and amended if care staff raised concerns about people's care needs, such as changes in their mobility, or in their health needs. The concerns were forwarded to the appropriate health professionals for re-assessment, so that care plans always reflected the care that people required.

People were given a copy of the agency's complaints procedure, which was included in the service users' guide. People told us they would have no hesitation in contacting the senior staff if they had any concerns, or would speak to their care staff. The senior staff dealt with any issues as soon as possible, so that people felt secure in knowing they were listened to, and action was taken in response to their concerns. Senior staff visited people in their homes to discuss any issues that they could not easily deal with by phone, and said that face to face contact with people was really important to obtain the full details of their concerns. There was no history of any missed calls over the preceding months, but the registered manager said that if any calls were missed this would be taken very seriously and treated as a complaint, and there would be a full investigation.

The complaints procedure stated that people would receive an acknowledgement of their complaint within two days, and the agency would seek to investigate and resolve the complaint within 28 days. The registered manager said they would have no difficulty in apologising to people if the agency had been at fault with any of their care provision. The agency had received two complaints during the past year. These had been appropriately investigated and resolved.

Staff were trained in how to deal with concerns or complaints, and were told that concerns could be about anything. They were taught to listen carefully and openly to what people said; record the information; repeat the details to ensure they had fully understood the person; and reassure people that their concerns would be taken seriously. If concerns related directly to any care staff, they were excluded from that person's care package until a full investigation had been completed. The senior staff would work with people to change their care staff if they did not like them or there were personality clashes. However, this did not usually happen as the registered manager was careful to try and match staff to people appropriately when the care package commenced.

Good

Is the service well-led?

Our findings

People spoke highly of the registered manager and the agency, and said that staff listened to them. One person had told the registered manager that they wanted the same member of care staff for their weekly session of one and half hours. The person's wishes were accommodated and they were happy with service. Several people commented that they did not think that travelling time for care staff had been taken into account. However, we found that this concern had already been identified and addressed, as extra time between calls had been added in, to start from the following week.

The registered manager had been in post for just over a year and had 20 years previous experience in agency work. She had concentrated on consolidating existing processes and bringing about changes. The agency had changed its offices within the same building shortly after her appointment as manager, and this had been an initial challenge. She had set targets for visiting officers to bring staff supervisions up to date, spot checks, risk assessments and care reviews, and this work had now been completed. The service had recognised the growing population of older people in the area, and were working with other branches of Mears Care to develop a project with Age UK in regards to 'Tackling loneliness in Older People'. This had resulted in carrying out events so that people living at home could have something special to join in with during the year.

The registered manager attended a quarterly meeting with other Mears Care registered managers, and communicated their ideas and agreed changes to the staff via a business update. Staff were able to raise their own ideas, and said that they were listened to, and felt part of the agency as a whole. The update included phrases such as , "This is your company, everyone has a role to play". They were encouraged to inform the registered manager or visiting officers of the topics they would like to see covered at the next meeting, and their feedback was viewed as important. The agency had been successful in supporting the local Clinical Commissioning Group with people who needed end of life care and specialist care packages, where care staff had been working closely with nursing staff. (Clinical Commissioning Groups have the responsibility for commissioning the majority of GP services and the associated community nursing services).

People were invited to share their views about the service through quality assurance processes, which included phone calls from senior staff; care reviews with visiting officers; yearly questionnaires; and spot checks for the care staff who supported them. This process was agreed when the registered manager carried out the first visit, and people were pleased to know that someone would be coming in to check that care staff carried out their tasks correctly. This had the added benefit of enabling people to get to know the visiting officers, as well as their usual care staff. If any concerns were identified during spot checks this was discussed with individual staff members, and staff told us their visiting officer advised them of any changes they needed to make.

The computer records showed that all telephone calls were documented, and they showed that action was taken to address people's comments or requested changes. For example, if someone had an early hospital appointment, they might request a visit from care staff earlier than usual to enable them to be ready on time.