Staff Management Limited

Active Assistance - Sevenoaks

Inspection report

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Date of inspection visit:
16 May 2018
17 May 2018
25 May 2018

Date of publication:
08 August 2018

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?	Good ●

Summary of findings

Overall summary

The inspection took place on 16, 17 and 25 May 2018 and was announced to ensure that the management team and people using the service would be available during the inspection.

This service is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community and supported living homes. It provides a service to children, young people, adults and older people, with physical disabilities and a wide range of diagnoses and health needs. Active Assistance provided support with personal care to 392 people across the country when we inspected. Active Assistance has a registered office in Sevenoaks and five regional managers based across the country. The regional managers have care service managers and personal care assistants who support people who use the service. All paperwork and information is sent to and stored in the Sevenoaks office.

At the time of our inspection there was a registered manager at the service. 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.

People were being kept safe from abuse. Staff understood their responsibilities in keeping people safe from abuse and had been trained to know how to report any possible concerns. People were supported safely around risks and were encouraged to take positive risks after control measures were applied. Staffing levels met people's needs safely and people told us that they had staff to support them when they needed it. There were emergency plans in place for people living at home who required staff to meet their medical needs.

People received their medicines safely and when they needed them by staff trained to administer them. The risk from infection was reduced by effective assessment, training and the provision of personal protective equipment. When things went wrong the service had learned from these and had shared that learning with staff teams.

People had received an assessment of their needs and their needs were tracked though care plans to ensure effective outcomes were achieved. Staff had the necessary skills and competencies to support people and had been trained in key areas such as safeguarding, moving and handling, and food safety as well as in additional areas that met people's needs, such as catheter care. Staff were supervised effectively and had annual appraisals

People received enough food and drink to maintain good health. Staff worked in partnership to provide consistent support when people moved to or from the service. People had access to healthcare professionals and were supported to maintain good health. Staff responded in a timely way when people were unwell and medical guidance was followed correctly.

People were supported to have maximum choice and control of their lives. Staff supported people in the least restrictive way possible; the policies and systems in the service supported this practice. The principles of the Mental Capacity Act were being complied with and any restrictions were assessed to ensure they were lawful, and the least restrictive option.

Staff treated people with kindness and compassion. Staff knew people's needs well and people told us they liked and valued their staff. People, and where appropriate, their relatives were consulted around their care and support and their views were acted upon. People's dignity and privacy was respected and upheld and staff encouraged people to maintain their independence as safely possible.

There was a complaints policy and form, available to people. Complaints had been utilised to improve the service. People received a pain free and dignified death at the end of their lives. Staff supported people with compassion and worked with local hospice teams. People were supported in a personalised way that reflected their individual needs. People's care plan documentation was written in a way they could understand and it reflected their needs.

There was an open and inclusive culture that was implemented by the management team. Audits and governance systems were effective in providing a high-quality service. People and staff spoke of a friendly and homely culture that was empowering. People, their families and staff members were engaged in the running of the service. There was a culture of learning from best practice, and working with other professionals and local health providers to ensure partnership working resulted in good outcomes for people.

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 ●

Active Assistance was safe.

People were safe and were protected from the risk of potential harm and abuse.

Risks to people, staff and others had been assessed and recorded and control measures were effective in reducing potential harm.

There was a sufficient number of staff to ensure that people's needs were consistently met. Safe recruitment procedures were followed in practice.

People who received support with their medicines did so safely.

The risk of infection was controlled by staff who understood good practice and used protective equipment.

Lessons were learned when things went wrong and accidents and incidents were investigated and learning fed back to staff.

Is the service effective?

Good ●

Active Assistance was effective.

People received assessments that ensured effective support outcomes were set and achieved with reference to national guidance.

Staff received effective training to meet people's needs. An induction and training programme was in place for all staff.

People were supported to eat and drink enough to maintain good health and this was monitored effectively by staff.

Staff members worked effectively with other agencies and organisations wen people moved to or from the service.

People were supported to remain as healthy as possible and had access to healthcare professionals.

Staff understood their responsibilities under the Mental Capacity Act and used these in their everyday practice. Staff understood the importance of gaining consent from people before they delivered any care.

Is the service caring?

Good ●

Active Assistance was caring.

People were supported by staff who were kind and caring.

People were involved in the development of their care plans and had been supported to make decisions around their care.

Staff respected people's privacy and dignity and encouraged their independence.

Is the service responsive?

Good ●

Active Assistance was responsive.

People received personalised care and their needs were assessed, recorded and reviewed with their input.

A complaints policy and procedure was in place and available to people.

People had a dignified and pain free death at the end of their lives.

Is the service well-led?

Good ●

Active Assistance was well-led.

There was an open culture where staff were kept informed and able to suggest ideas to improve the service.

There were effective systems for assessing, monitoring and developing the quality of the service being provided to people.

The views of people, their relatives and staff were actively sought and acted on.

The service continuously learned and improved and had effective audits of quality.

The service worked effectively in partnership with other agencies.

Active Assistance - Sevenoaks

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.

The inspection took place on 16, 17 and 25 May 2018. We gave the service 48 hours' notice of the inspection visit because it is office based and the manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started on 16 May 2018 and ended on 25 May 2018. It included direct observation of care and support, interviews with people, their relatives and staff employed by the service, and review of care records and policies and procedures. We visited the office location on 16, 17 and 25 May 2018 to see the manager and office staff; and to review care records and policies and procedures. We also visited some people in their homes to speak to people and observe the care they received.

The inspection team consisted of four inspectors. We spoke with the registered manager, the operations manager, the director of quality, nine carers, 35 people and four people's relatives. We looked at 13 people's care plans and the associated risk assessments and guidance. We looked at a range of other records including four staff recruitment files, the staff induction records, training and supervision schedules, staff rotas, medicines records and quality assurance surveys and audits.

This is the first time the service had been inspected under the new registration.

Good ●

Is the service safe?

Our findings

There were effective systems and processes in place to keep people safe from abuse. The service kept a safeguarding database that was available to the registered manager and senior managers. It collated a log of all safeguarding referrals and enabled managers to track if the same staff or same person was referred. There was a record of all open safeguarding's and a further list of safeguarding issues that were classed as requiring 'monitoring', where the referral had been closed but the issue may recur. The registered manager had been pro-active and referred some incidents that did not meet the threshold for safeguarding. All incidents had been referred appropriately to the relevant local safeguarding team and notified to the Care Quality Commission. The provider's safeguarding policy was up to date and contained a description of the newer definitions of abuse, such as modern slavery and self-neglect. There was a safeguarding children policy that referenced the relevant legislation, such as The Children's Act 2004 and The Children and Family Act 2014. There was clear guidance for staff on what to do if a child disclosed allegations of abuse or is a staff suspected abuse. Staff were knowledgeable about safeguarding and confident on how to report concerns. One staff told us, "I would know how to recognise different signs of abuse. There are different kinds [of abuse]. I would look if someone is for example, depressed or acts differently around other people."

Risks had been identified and mitigated within people's care plans with detailed guidance for staff on signs to look for and when to call the GP, district nurse or emergency services. People had individual risk assessments to mitigate any potential hazards they may face. Risks to people were assessed and managed safely without unnecessarily restricting people's freedom. For example, one person was identified of being at risk of choking, and had a feeding tube sited in their abdomen. However, the person's goals detailed that they wanted to drink tea for as long as they could, and following a speech and language therapy assessment the person had made the choice to continue drinking tea. Staff supported the person to drink through an adapted cup with a straw, and encourage the person to double swallow to reduce the possibility of them choking. People's accommodation had been risk assessed to ensure the safety of people and staff. Where people relied upon their care package there were service failure plans in place that identified family members who would be responsible for continuing the care package in an emergency.

There were sufficient staff deployed to meet people's needs and to keep them safe. The staffing levels each person required had been determined by care service managers who assessed potential clients and worked out what level of support was required. For example, when a person required tracheostomy care this was assessed as needing two carers in the day and night. A tracheostomy is an opening created at the front of the neck so a tube can be inserted into the windpipe to help a person breathe. Once the level of care had been established a support team was recruited, so a person requiring four carers per day would have a team in excess of 10 staff. There was a spreadsheet used to track the number of hours for each client, a list of staff inducted to work with the person and any shortfall. There were contingency plans to address emergency staff shortfalls. For example, there was a shortfall, for one person, of 26 hours per week that were being worked as additional hours by carers.

Safe recruitment processes had been followed and recruitment systems were robust. The ten files we reviewed evidenced that people had been recruited in line with the provider's processes and checks were completed to ensure people were of good character. Criminal records checks had been made through the Disclosure and Barring Service (DBS), and staff had not started working at the service until it had been established that they were suitable. The DBS helps employers make safe recruitment decisions and helps prevent unsuitable people from working with people who use care services. In some cases, where staff had been recruited from abroad, overseas criminal record checks had been reviewed, and translated to support the recruitment decision. Each staff member had two references, obtained from their most recent employer where possible. Where the provider employed nurses there were regular checks of their PIN to ensure they were registered to work as a nurse with the Nursing and Midwifery Council.

People received their medicines safely. There were safe medicines administration systems in place and people received their medicines when required. The vast majority of people being supported with personal care managed their own medicines. People had medicines care plans and were assessed as being at one of three levels: level one, minimum assistance; level two, support required and level three, specialist care. For example, people who received their medicines via a PEG tube were designated as, 'level 3 administration of medication via a specialist technique. PEG stands for percutaneous endoscopic gastrostomy, a procedure in which a flexible feeding tube is placed through the stomach. A PEG allows nutrition, fluids and/or medications to be put directly into the stomach, bypassing the mouth and oesophagus for people at risk of choking. People consistently told us that they received their medicines when they needed them. One person told us, "I get my medication on time. Obviously when a new carer comes in I monitor things and they ask me if they are not sure." The registered provider had a medicines policy that was up to date and contained relevant information on areas including training, consent and medicines for children and young people. Medicines audits had been completed regularly and had been done following a spike in incidents.

People were being kept safe against the risk of infection by the prevention and control of infection hazards. People had infection control plans in place to minimise the risk of infections. These highlighted specific risks including urinary tract infections, chest infections, wounds and cross infections from bodily fluids. Control measures had been identified such as care staff adhering to strict hand washing procedures before and after care tasks. Care staff had access to personal protective equipment such as gloves, aprons and shoe protectors. One person's infection control plan gave a list of the possible signs of infection if present in the person and instruction to call the GP or district nurse for advice if seen. One person old us, "Active Assistance provide the gloves and they're always available. I choose not to have a toilet door on my own toilet to stop others from using it and reducing the risk of cross infections." There was an up to date infection control policy in place and the provider had appointed an infection control champion as per national guidance.

Staff understood their responsibilities to raise concerns and report incidents. Accidents and incidents had been recorded and investigated appropriately. The registered manager had identified two main areas of learning in the past 12 months. One had centred around a person in hospital on ventilation and whether responsibility for care sat with the hospital as the person was in their care and using their equipment; or was the lead agency the Active Assistance as they were providing carers for the person. A root cause analysis was completed and as a result a hospitalisation protocol was created. The protocol went in to detail around who has responsibility for people's care and id signed by the hospital and Active Assistance. Another lesson learned was around clients who do self-directed clinical procedures. One person was directing their care staff who to complete a bladder wash the way they like it to be done. A bladder washout is a technique used to flush out the catheter (a tube in to the bladder) and bladder by introducing a catheter maintenance solution into the bladder through the catheter. The person became ill due to the procedure they were using. As a result all self-directed clinical procedures were stopped. An audit was completed to identify all self-directed care procedures and a policy was changed to ensure that all procedures were subject to a clinical sign off from a manager.

Good ●

Is the service effective?

Our findings

People's needs were assessed and their care was delivered in line with current legislation. The service received referrals from professionals such as those at specialist hospitals, or directly from people who wanted to use the service. Staff met with the person to discuss their needs, and used information from health professionals including occupational therapists and physiotherapists to assess whether the service could meet those needs. The assessment considered people's protected characteristics under the Equalities Act, such as their ethnicity, culture or faith. This helped ensure there was no discrimination when making decisions about people's care. It took into account people's capabilities as well as their physical needs and emotional wellbeing. The assessment was used by the person and staff to draw up a person-centred care plan, which showed how and when the person wanted to be supported. The service used technology and equipment to promote peoples' independence wherever possible. For example, one person used a wireless speaker system to contact their care staff when they were in a different part of their home.

People were supported by staff members who had appropriate skills, knowledge and experience to deliver effective support. Training initially took place over five or six days, depending on the complexity of the people the new staff would work with. All staff had to pass their training in order to be confirmed in their role, or to continue working for Active Assistance. Staff told us training was tailored around people's needs. One staff told us, "People's conditions are personal to them, and everyone is different, therefore the training has to be person centred." When they assessed a new client, and they did not currently have a training course to support that specific need, then their team of clinical managers created the relevant training course. Attitudes and personalities were assessed during the training to ensure potential staff were of the right character, which staff told us was important as they would be lone working with vulnerable people. Training was delivered in person, and staff then had the opportunity to practice any procedures on training dummies. Following this they completed competency checks in the community with a buddy. Staff were signed off to lone work after passing this process. Staff told us one person enjoyed working with newer care staff and, "showing them the ropes", helping them to improve and contributing to the organisation which they, "really enjoyed".

People were supported to eat and drink enough to maintain a balanced diet. People's care plans contained guidance for staff on the extent to which the person wanted to be supported with their meals. For example, one person's care plan indicated they wanted to be in the kitchen when food was being prepared, but did not want to prepare vegetables as they thought this took too long. Where risks to people had been identified relating to their eating and drinking, they were recorded in care records and provided guidance to staff so they knew what action to take to reduce them. When necessary, staff used a Malnutrition Universal Screening Tool ('MUST') to help ensure people received the right amount of food to keep them healthy. 'MUST' is a five-step screening tool to identify adults, who are malnourished, at risk of malnutrition (under nutrition), or obese. It also includes management guidelines which can be used to develop the person's care plan. People with more complex health needs were referred to health professionals for specialist guidance. For example, where one person was at risk of losing weight, a dietician provided guidelines to staff on how to encourage them to eat more, and the healthiest food they should be eating.

There was a clear process for supporting people when they moved from or were referred to the service. The provider has a 'transfer of service procedure' staff worked to. The aim of the process was to '…endeavour to make the transition from one service to another as smooth as possible for the clients, for new service providers and for the commissioning authority'. Staff told us of an example of one person who was no longer able to manage at home, and supported to move into residential care. Staff supported the person at the meeting with the commissioning group where the move was discussed and shared the person's documentation with the residential service. The provider supported the person for a period of four weeks, providing their regular PA to provide the person with consistency. Staff told us the person informed them they had helped to reduce their anxieties and made them feel safe.

People with very complex health needs received the care that they required. People had been supported to live healthy lives and had access to health and social care professionals. People had access to a GP, dentist and an optician and could attend appointments when required. One person with a tracheostomy (an opening created at the front of the neck so a tube can be inserted into the windpipe to help a person breathe) had a very detailed breathing care plan. It described how breathing was affected in different ways, e.g. lung capacity and secretions. The person used a ventilator to aid breathing and this was clearly described. The plan indicated an oxygen level at which action needed to be taken and what action staff should take. There were detailed instructions for the care and use of the ventilator, tracheostomy tube, for oxygen therapy and the nebuliser. Risks around infection were made clear in the plan and staff were directed on what to look for and what action to take to meet the persons health needs. This level of planning around complex health needs was apparent in all of the care plans we reviewed. For example, when a person was receiving support had an issue with their skin that could cause health problems if not monitored correctly and the management plan around this was robust. One person told us, "They look after my skin care really well." People with spinal injuries were encouraged to complete exercises. Physiotherapists had trained care staff in the exercises people should complete and carers then encouraged people with disabilities to complete their exercise routines.

People were asked for their consent before care was given and they were supported and enabled to make their own decisions. 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. The authorisation procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). In domiciliary care this is called Court of Protection. There were no people who required Court of Protection restrictions at the time of the inspection

We checked whether the service was working within the principles of the MCA. People's right to make decisions was promoted and the principles of the MCA were adhered to. For complex decisions, such as one person who wanted to have their ventilator turned off, a wide circle of professionals were involved in assessing the person's capacity around the decision in a multi-disciplinary team. For other decisions, such as one person choosing to eat after they had been assessed as not being safe to eat, the registered provider used their own MCA form to establish whether the person had capacity to make this decision and to ensure that any decisions made around restrictions were lawful.

Good ●

Is the service caring?

Our findings

People were treated with kindness and compassion by their staff and were given emotional support when needed. One person told us, "Staff are kind and caring. Empathy is one of the big things I look for [in staff]." One person told us about a time they had lost a silver ring whilst out in the fields behind their home. A carer had returned to the person's home, found a metal detector and scanned the whole route until they found the ring for the person. Another carer had removed tics from a person's dog when the person found them. One person commented, "[Carer] will make muffins when without me asking them to; they don't have to make these but it shows kindness." One staff told us how they took care of one person's garden, "I tend to the garden because it makes [name] happy. We cut down a tree two days ago and set up a bird bath; so they are happy, I'm happy. Its' good to build relationships."

Staff knew and respected the people they were caring for including their preferences, personal histories, and backgrounds. One person told us, "I have a profile in my care plan. Whether they have been before or not they always read the care plan to check the care I need whether anything has changed." Most people had a small group of workers that they were familiar with and a person-centred plan with personal goals and outcomes. People spoke with their staff in a relaxed and friendly manner and engaged with activities together. Staff knew people's needs well and were respectful. One person was going to a concert in London with their support staff the next day. Both people and their staff spoke with enthusiasm about the concert; there was a conversation about which bands the person had seen in the past and who the best was.

People were supported to express their views and be actively involved in making decisions about their care and support. People confirmed to us that they had a yearly meeting with a care support manager where they read through their care plans. This process was to update and review the care plan. One person told us, "We go through what changes there are, e.g. a physiotherapist leaving or any different equipment I am using. We talk it through in the afternoon and then a copy is sent to me to sign." People were able to direct their care and support in an individualised way. One person with a spinal injury described to us how they had a unique process for evacuating their bowel. They told us, "I have a bespoke care routine that suits my needs and has been adapted to my needs. The carers all follow it in the way I want."

People's right to privacy and dignity was respected. One person told us "Staff will respect my privacy. All I have to say is 'you're not needed now', we have that understanding." One staff member commented, "Every time [name] goes in to his room I close the door. If they are speaking on the phone I back off and give them some time."

Staff understood how to communicate with people to achieve positive outcomes. One person told us, "Obviously the communication between us is very good so they would ask me how I like things done." People's care plans contained clear guidance for staff on how people communicated. One communication care plan described how the person's voice was strong and they were able to verbally direct their own support. Another care plan described how staff would need to set up an electronic tablet, so that the person could access email, telephone and internet independently. The plan also described how tiredness could affect the person's verbal communication and what staff should do to help the person and reduce their frustration. Another person used an electronic communicator to make their voice heard, and to write emails. Risks to that person becoming anxious whilst being in the shower and unable to use their communicator had been identified and mitigated effectively.

People's independence was promoted by the service and skills training and supporting independent living had been the driving ethos of the service. Staff worked alongside people to help them to achieve and maintain their independence. One person told us, "Staff help me to be independent by just doing the work they do. If my family had to care for me I wouldn't be independent. With a carer I can live alone, away from my family, how I choose to." Another person commented, "Staff don't just jump in and take over; they wait for me to ask for any assistance. I try to be independent."

Good ●

Is the service responsive?

Our findings

People received an individualised service that was tailored to their needs. Comments from people included, "I have a wonderful co-ordinator at the moment who really listens to one's needs", "I'm really happy with this agency", "They understand specialised needs and they choose appropriate staff" and "The agency are immediately responsive if you tell them a carer isn't quite suitable." Each person was involved in drawing up their own care plan which considered their strengths, how they wanted to be supported and the support they required. Care plans included details about the person's routines, such as when they like to get up in the morning, if they like to have a shower before or after breakfast, and how they want to self-direct their support. The registered manager told us, "It's the person's care plan and they can include whatever information they want. We can help them complete it but some people compile it themselves and send it to us." People could be involved in the recruitment of their personal assistant if they wished to be, and when support began each person had access to a named coordinator who would support the person and PA when support commenced. When people's needs changed their care plan was amended to make sure staff had access to the most up-to-date information. Formal reviews took place monthly when support started and annually once it was established. When personal assistants changed there was a handover period of between four and 48 hours depending on the complexity of the support being provided.

Active Assistance's stated goal was to support people to live as independently and individually as possible, and supporting people to achieve their aims. This was achieved through person centred care planning. Care plans were personalised and described how people liked to receive their care. We reviewed one person's 'person centred assessment'. It contained tailored information important to the person, such as preferring to have the TV on very loud despite having no hearing problems. People's care routines were described in detail, such as which shampoo to use, or how the person stood up in the shower. People's past lives were recorded including where they grew up, what their birth family was like, whether they were married and if they had children or grandchildren.

People and staff engaged in tasks together and support was directed by the person. Staff asked people how they wanted food prepared. People's preferences were met, for example one person liked tomatoes to be warmed and not cooked, and preferred pitta to sliced bread, and these choices were provided. Staff did things in the way that people wanted, for example, cooking and cleaning in a certain order. People's daily routines were set out in their care plans in a personalised way. For example, the order in which a person liked things to be completed, or having specific drinks at certain times was explained clearly. We checked with people and they were able to tell us examples of this in practice such as one person having ginger tea with hot water in a specialised adapted mug.

Complaints and concerns were documented and responded to effectively. The service kept a log of complaints received, and aimed to respond to all complaints in 72 hours, and resolve them in 28 days, and all complaints we reviewed met these deadlines. There was a complaints policy in place, which included how and who to escalate complaints to, including the local government ombudsman if people were not happy with the complaints' resolution. Complaints were analysed quarterly and yearly, with learning and improvements discussed during manager meetings, and passed down to the teams through line managers.

When people moved in to the service they were presented with a pack of information and a copy of the complaints policy was included. The complaints log had recorded 17 complaints in the 12 months before our inspection. There was a 28 day deadline for the provider to provide a formal response to complainants and a 72 hour timeframe to initially respond to the complaint and his had happened in all cases.

People and their relatives all told us that they were aware of how to complain and who they could complain to if the need arose. Staff members were aware of the complaints policy and the procedure for dealing with complaints, including how to support people to complain. One staff member told us, "All complaints go to the manager and they get sent to the head office. All residents and families are given phone numbers on how to complain and if there is anything to learn from the mistakes we would talk about it at staff meetings."

People who were receiving end of life care were supported to have pain free and dignified deaths. Staff supported people effectively with palliative care. Palliative care aims to treat or manage pain and other physical symptoms associated with a life limiting illness. One care plan we reviewed had an end of life decisions plan which recorded that the person did not have any specific wishes regarding their death. However, the person's care plan had been reviewed and amended to account for the effects of the person's diagnosis. For example, a relative had been identified in case the person was unable to make future decisions. Staff had been directed to respect the person's privacy and allow friends and family time with the person. The importance of keeping the person pain free and comfortable had been identified and there was a Macmillan nurse and community palliative team in place to help manage the person's pain. Other considerations such as behavioural changes and skin integrity issues related to the person's illness had been planned for effectively.

Good ●

Is the service well-led?

Our findings

The registered provider had a clear vision, with staff and the registered manager working to the established values of the service. The registered manager was responsible for overseeing the day to day culture of the service day to day, which people, staff and relatives told us was person centred and empowering. The registered manager ensured that staff felt supported, respected and valued, and were motivated in their work. Staff were mentioned in an end of year thank you in the staff newsletter. A new 'PA liaison officer' post had been created to provide care staff with a dedicated person to share any problems or concerns. There was also regular carer meetings and a monthly recognition award. Leadership within the service was visible and capable at all levels and inspired staff to provide a quality service. There was a private log in area on the provider's website where staff could give feedback in private, so that care staff who worked nights or late shifts could seek management input. Staff and managers shared an understanding of the key challenges, concerns and risks facing the service. The registered manager had identified that one main challenge facing the service was in recruiting staff from the UK given the proposed exit from the EU. The provider had been supporting staff from overseas to apply for work visas and investigating shorter live-in periods that would be more attractive to UK based staff.

The registered manager was aware of their responsibility to comply with the Care Quality Commission (CQC) registration requirements. They had notified us of events that had occurred within the service so that we could have an awareness and oversight of these to ensure that appropriate actions had been taken. They were aware of the statutory Duty of Candour which aimed to ensure that providers are open, honest and transparent with people and others in relation to care and support. The Duty of Candour is to be open and honest when untoward events occurred. The registered manager confirmed that all incidents that had met the threshold for Duty of Candour had been reported to people's relatives. The registered manager was given good support from their line manager who supervised and appraised their performance and oversaw quality monitoring with the registered manager. It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so people, visitors and those seeking information about a service can be informed of our judgements. The provider had displayed the rating conspicuously in the service.

The registered manager was supported in their role by the board. The registered manager is part of the provider's executive board. The registered manager told us, "I mentioned at a board meeting how we were getting more calls about the mental health wellbeing of overseas staff, especially lone workers. The CEO found an employment wellbeing programme and asked me to meet with them and we are implementing this." The provider had ensured that it had robust arrangements for the security, sharing and integrity of confidential information in line with data security standards. There was an information governance team who oversaw compliance around data management. There had been data breaches where a staff accidentally sent a blanket e-mail so staff could see each other's e-mail addresses. Following this e-mail distribution lists were introduced and there had been no further data breaches.

People, their families and staff members were involved in the service and regular feedback was sought through meetings and questionnaires. Staff had been actively involved in developing the service and were encouraged to be involved in proposing new ways of working. One staff had attended a values based recruitment workshop and asked to review the organisations values. The registered manager appointed the staff member to lead on the project. The registered manager commented, "We did a survey and sent it to our clients to ask what our values should be and they said, choice, compassion, reliability and integrity. All departments were also asked to give their values." People were sent regular surveys by the provider. We reviewed the results of one of these surveys and saw that the responses were largely very positive. Surveys are analysed and results displayed in charts and discussed at board meetings. The provider had strong links with other organisations such as the Spinal Injuries Association, with key staff attending working groups and helping to shape campaigns, such as compliance with the National Living Wage for members of the association who employed their own carers. Active Assistance also supported other organisations, such as Back Up Trust who provide a range of services to people with spinal injuries. The provider had attended fund raising balls and sponsored runs to raise money for the trust.

The provider had effective quality monitoring systems in place to ensure the service continuously improved and achieved sustainability. There was a quality and governance team managed by a registered nurse who oversaw audits from a clinical perspective, whilst the registered manager oversaw audits from the operational side. The provider was auditing against ISO 9001 standards. ISO 9001 standards are international standards used to demonstrate the ability of an organisation to consistently provide services that meet regulatory requirements. The quality and governance manager ran audits and looked for any trends. These reports were then reviewed at quality management meetings with heads of departments to discuss the audit and formulate an action plan for each department. These action plans were risk rated and had clear lines of accountability. Action had been allocated to people with timescales for completion.

Resources were available to develop staff teams and drive improvement. The provider had a continuing professional development policy that stated staff could access training additional to their role and feedback learning to the staff team. Nurses had to complete their re-validation with the Nursing and Midwifery Council and were supported with a minimum of 35 hours per year. Information form incidents had been used to drive quality improvements. Incidents were included in management report where they are analysed, so if a trend is identified training could be provided. A health and safety team met every quarter and made improvements such as changing the return to work form to include more details about people's ailments and whether an assessment is required before the staff can return to work.

The registered manager had a good working relationship with the local services and was working effectively in partnership with key organisations. The provider was working effectively with Clinical Commissioning Group's (CCG). CCGs are NHS bodies responsible for the planning and commissioning of health care services for their local area) to provide assessed levels of care for people. Where some people's care had not been reviewed the provider was sending monthly reports to some CCG's. Where people's care packages were not funded by CCG's the provider worked closely with care managers and employed business development managers to work with new funding bodies. There was evidence of close working with different health teams around the country such as speech and language therapy, district nurses, physiotherapists, and GP's. The provider had also been working closely with children's services such as schools and at looked after child reviews. The service had been sharing appropriate information and assessments with other relevant agencies. The registered manager and provider were aware of the changes to data protection coming in to force and there was a strategy in place to ensure compliance with the changes. Confidential e-mails were sent in an encrypted format and password protected.