Dynavour Care Services Limited

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Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

We last inspected this service at its previous registered location [main office] in October 2014 and found the provider was meeting all of the requirements of the regulations at that time. This inspection was announced and took place over three days on 14, 15 and 19 January 2016.

Dynavour Care Services Limited, hereafter referred to as 'Dynavour', is registered with CQC to provide personal care for people in their own homes in the Gloucestershire area. People receiving support may live with a learning disability, mental health problems and / or a physical disability. At the time of the inspection the service was providing support for approximately 70 people, however only 10 of these were receiving personal care, which is regulated by CQC. The service is required to have a registered manager in post. The registered manager had been registered as manager at the service since 2010. 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 benefitted from a reliable and flexible service which put their needs and wishes first. People were valued as individuals and were supported to become as independent as they could be and to maintain or rebuild relationships with people who were important to them. They benefitted from positive relationships with the staff who supported them and were routinely signposted to community services that often improved their health and mental well-being. People's safety and well-being was maintained and enhanced through effective links with other community health providers, community services and support with benefit applications. People were respected as individuals and their right to make decisions about their lives, including potentially unwise decisions, were upheld. When people lacked capacity to make decisions the Mental Capacity Act was adhered to.

Staff enjoyed working at Dynavour and spoke highly of their colleagues. They worked well as a team and respected each other's contribution, knowledge and experience. Staff felt well-supported and valued. They were able to speak openly and discuss issues or difficulties they, or the people they supported, were experiencing, so that solutions could be found. They cared for the people they supported and considered their needs holistically, being aware of and responding to changes in people's day to day well-being, to ensure they were safe. Staff acknowledged people's contribution and hard work in helping themselves to become more independent and stay well.

The service worked openly and in close collaboration with health service providers, local community services and local authorities. Strong leadership was provided by the registered manager who was highly experienced, well-respected in their field and took an outward facing approach; working in line with national policy, guidance and research recommendations. Managers worked closely with staff and were always available to provide support and advice; they knew of significant events happening within the service each day. They were aware of needs within their local community and worked inclusively with people, staff and

other organisations to develop the service in line with people's wishes and local needs.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People were safeguarded from the risk of abuse because staff knew what to be aware of and how to report their concerns.

People were protected against health related and environmental risks. Staff remained with people in an emergency ensuring they stayed safe.

People's medicines were managed safely. Strategies were in place to monitor and check on staff competency when administering people's medicines.

There were enough staff to meet people's needs and robust recruitment practices protected people from the employment of unsuitable staff.

Is the service effective?

Good

The service was effective.

People were supported by staff with the knowledge and skills to carry out their roles. Staff understood people's needs and preferences.

People's rights were protected under the Mental Capacity Act (2005) because staff adhered to the legislation.

People had access to a healthy diet which promoted their health and well-being, taking into account their preferences and nutritional requirements.

People's health care needs were met. Staff made prompt referrals to obtain specialist support where needed and specialist advice was followed.

Is the service caring?

Good

The service was caring.

Staff developed positive relationships with people who used the service. People were treated with respect, kindness and

compassion.

People felt listened to and had been involved in making decisions about their care.

People's dignity and privacy was maintained and their independence was promoted.

Is the service responsive?

Good

The service was highly responsive.

People received holistic personalised care and were regularly consulted to gain their views about the support they received. Where people were unable to give their views about their care, their representatives were routinely consulted.

Staff knew people well and could tell us about their individual preferences and interests. People were enabled to maintain relationships with those who mattered to them, achieve their goals and successfully reintegrate into the community.

When people's needs changed their care was adjusted to reflect this and their care records updated.

There were arrangements in place for people to raise their complaints and to have these listened to, taken seriously and addressed.

Is the service well-led?

Good

The service was well led.

Managers promoted an open and inclusive culture. The vision and values of the service were demonstrated by staff in their interactions with people and with each other.

The registered manager was accessible to staff, people and their representatives. They actively sought feedback to improve the quality of the service and felt supported by the provider. Staff felt supported and understood their roles and responsibilities.

Quality assurance systems which included the views of people using the service were in place to monitor the quality of care and safety of the home.

Dynavour Care Services Limited

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 14, 15 and 19 January 2016 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in. One inspector and a specialist advisor carried out this inspection. A specialist advisor is a professional person who has experience of this type of care service. The specialist's areas of expertise were domiciliary care, mental capacity and deprivation of liberty, dementia, sensory loss, learning and physical disabilities. The service was providing a regulated activity to 10 people at the time of our inspection.

Before the inspection we reviewed information we have about the service including notifications. A notification is a report about important events which the service is required to send us by law. We had also received information from a local commissioning team.

As part of this inspection we spoke with six people using the service, three relatives, the registered manager and their deputy, the staff member responsible for recruitment, the staff member responsible for staff rotas and five care staff including one of the team leader's. We reviewed the care records for six people and four medicines records. We also looked at the recruitment process for seven staff, training records and quality assurance systems including health and safety records. We observed the care and support being provided to two people. We contacted three health and social care professionals.

Good

Is the service safe?

Our findings

People were protected from the risk of abuse because staff had the appropriate knowledge and understanding of safeguarding policies and procedures. Staff had completed training in the safeguarding of adults and understood how to recognise and respond to potential indicators of abuse, such as a person becoming withdrawn. Information about local safeguarding procedures was accessible to staff. A staff member said, "I would whistleblow without a doubt, I wouldn't have a problem". They had confidence any concerns they raised would be listened to and acted upon. A safeguarding matter was raised to us during the inspection; this was responded to promptly and appropriately by the registered manager. People's comments included, "I'm very happy and well treated… There's not a one [staff] that isn't good. I do feel safe, I've never had any cause for concern" and "I feel quite safe; They look after me very well indeed".

Risk assessments were in place to support people to be as independent as possible. These protected people and supported them to maintain their freedom. Example's included managing alcohol intake, arrangements for going out, preventing self-harm, managing weight and preventing falls. People understood the risks to them and told us how staff supported them to manage these. External agencies were consulted to ensure people's home environment and any equipment in use were safe for them. For example, the fire service had advised in managing risk for a person who was a smoker and had limited mobility. Another person received support from a physiotherapist and was referred to an assessment clinic following a fall.

The registered manager received a daily update from the staff team leader, which they acted upon as needed. This included accidents or incidents, changes to people's well-being or physical needs. All accident / incident reports were reviewed by the registered manager to make sure the appropriate action had been taken. For example, they had recently contacted a member of the person's mental health team to request a review.

Staff acted promptly to support people in the event of an emergency by calling for help and waiting with the person until they were taken to hospital. Similarly, when a person had told staff they were feeling suicidal, the Mental Health Crisis Team were contacted and attended the same day. Staff understood arrangements for entering people's homes such as where the key was kept or codes to enter buildings. Staff made sure people were safe and secure when they left them. If they had concerns about people's safety, for example, if they were not answering the door when expected, staff said they would contact the police.

People's safety had been considered should there be an emergency or untoward event. Some people had evacuation plans which described the assistance they needed to be safely evacuated from their home in an emergency. A disaster plan for emergencies had been updated in November 2015 and all staff had access to this. Staff confirmed the arrangements for them to contact senior staff out of normal working hours were effective. There was evidence that senior staff had covered visits where there had been last minute sickness or additional help was needed in an emergency.

People were involved in the recruitment and selection of staff. For example, a sad and smiling face sheet was used to capture a person's view about a staff member after they had completed their induction. Staff

were safely recruited as procedures were robust and included all required checks. This included obtaining evidence of satisfactory conduct in previous care roles and verifying reasons for leaving previous roles and Disclosure and Barring Service (DBS) checks. DBS checks alert providers to people that may be unsuitable to work with vulnerable groups. Home Office checks had been carried out, if indicated, to verify the applicant's right to work in the UK. Checks were completed before staff started working for Dynavour. Where checks revealed any risks, appropriate action was taken to assess and manage the risk. The staff member responsible for recruitment said, "If I wouldn't want them looking after my family, they wouldn't be employed".

The registered manager told us about strategies they were employing and planned to introduce to overcome difficulties in recruiting suitable staff. At the time of our inspection another six full-time staff were needed and regular agency staff were booked to cover shortfalls. The process in place for induction of agency staff was robust. A staff profile and DBS date were obtained from the agency to check suitability for the role. Agency staff worked alongside experienced staff members to be introduced to a person and their care needs. Information packs for agency staff detailed support the person required on a daily basis at a glance. Routine management visits to get feedback about staff performance and record keeping were carried out.

An electronic rota system was in place which required staff to log in and out by telephone when visiting people. This tracked the timings and length of visits and any delays. People received a weekly rota, one person said, "They always let me know who's working with me, I have a rota every week". People told us they received the full amount of time expected. If a visit was cut short due to staff availability this was agreed with the person and the time they were owed was made up. One person said, "If they are late there's always a proper excuse, they explain to me and do extra hours to make up for it. They're very very good I think". Commissioners were aware of these arrangements and one said, "They are good if not using the hours [Registered manager] will ring and say". Staff confirmed staffing levels were maintained, one said "[The staff member responsible for rotas] does a fantastic job" and confirmed the actions being taken to recruit staff. Feedback to the provider about how staff disciplinary matters were managed was positive. For example, an external professional said, "Have had issues with staff in the past which were resolved very efficiently".

People's medicines were managed safely and wherever possible people were supported to take care of their own medicines. People's needs were recorded and support with medicines was provided by staff with training in medicines administration. This training took place over two days and was followed-up with staff competency checks. Systems were in place to reduce the risks to people, including checking the stock received. These had proved effective as a staff member had recently found a dispensing error which was rectified before the medicine was needed. A health professional said, "They [staff] are picking up on concerns around medicines and have communicated these very well". All staff checked Medicines Administration Records (MAR) for missed signatures and stock levels to ensure people's medicines did not run out. Any shortfalls were communicated to the team leader and managers.

The registered manager told us they routinely checked MARs for gaps and stock levels on receipt in the provider's office, but did not record this. Further to the checks in place, a staff member was being supervised with medicine administration after shortfalls had been found in their practice. Discussion with the registered manager centred on how routine checks could be better evidenced and errors logged centrally to facilitate detection of any common themes. A member of the senior management team told us they planned to start doing this. Appropriate policies were in place to guide staff in medicine management including homely remedies.

Good

Is the service effective?

Our findings

People were supported by staff who had the knowledge and skills to meet people's needs. Their comments included, "Staff understand my needs… The whole care package I've got is extremely good. I feel lucky and privileged to have it", "We're all fine here, we're being looked after properly" and "The support workers are amazing… They look after me very well indeed".

The staff member responsible for managing rotas matched staff to people to provide as much consistency and continuity in their care and support as possible. In doing this, priority was given to people with significant support needs, they understood people's needs and said about some people in particular, "They are complex. They need consistency and need to know who's coming". They sought feedback from people and staff to understand who staff worked best with. A staff member said, "The service and the team here are very good. They are connected, hardworking and the input is very good. When I started, I shadowed [worked alongside] everyone. They were very informative and willing to share information, nothing was held back". Staff had regular one to one supervision meetings and told us they felt well supported in their roles. One said, "I've never worked in a place so long, something must be going right".

Staff were supported to complete qualifications in social care and all staff were completing the Care Certificate, irrespective of their existing qualifications. As well as all staff being updated in all required training, this had provided opportunities for staff to share knowledge and experience and discuss any problems they were experiencing. A staff member said "We debate between us". The registered manager also sought feedback from the external training provider about staff issues or leaning needs and said, "I speak to the trainer to see what they are picking up on". Staff worked closely with external professionals, including a team of specialist mental health nurses and crisis and recovery services, when planning and evaluating more complex care. Staff were enabled to keep up to date with best practice: A senior staff member said, "[Registered manager] is very good at pulling things [legislation, guidelines, reports] off the internet. We have a meeting once a week".

Appropriate consent was sought before care and treatment was given and people were involved in making decisions about their care. We observed staff checking with people before carrying out care and asking people what help they wanted. Our conversations with people confirmed the arrangements documented. For example, one person had capacity to manage their medicines but wanted staff to help them for the time being as their medicines were being adjusted which they found confusing.

We checked whether the service was working within the principles of the Mental Capacity Act (MCA) 2005. The 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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. The application procedures for this are called the Deprivation of Liberty Safeguards (DoLS). In domiciliary care and supported living setting DoLS applications must be made to the

Court of Protection (CoP).

Appropriate applications to the CoP had been made by the provider in conjunction with the commissioner's legal representatives. Records showed this was an effective working relationship and changes in people's capacity to make decisions, as their health improved or declined, were acted upon. For example, the DoLS authorisation for one person was being reviewed. Records made reference to evidence of improvement in their capacity, which required further assessment before a decision about their continuing need for DoLS could be made. Another person with a DoLS authorisation in place lived with a progressive illness which affected their movement, thinking, judgement and behaviour. Their support plan included a very personal and detailed account of their previous interests, occupations, lifestyle preferences and relationships. This provided important insight as they were no longer able to communicate these facts which could be taken into account when best interest decisions were made on their behalf. Our checks found the provider was complying with the court orders in place.

People's care plans were supported by MCA assessments for people unable to make decisions and as part of the act, records confirmed which decisions had been made in their best interests and who had been involved.

People's care plans prompted staff to make sure they had sufficient to eat and drink and had access to food which reflected their dietary and nutritional needs. People enjoyed the food provided and were able to eat at the time and place it suited them. Daily records demonstrated people were involved in choosing and shopping for their own food and they enjoyed a varied diet. Where possible they were also involved in preparing their own meals. People sometimes chose to eat out or order take-away. One person whose care we tracked required their food to be cut up for them; we saw that this was done in line with their care plan. People's weights were monitored, if this was indicated, and where any problems were identified, dietary advice and / or swallowing assessment by a health professional had been obtained.

People received timely support to access healthcare services and maintain their well-being. This included support to access routine health screening, dental care and specialist appointments. Records demonstrated people were referred for assessment promptly. For example, when a new person moved to the service they were assisted to register with a GP and were referred to a continence assessment service. Staff supported them to make routine appointments and attended monthly meetings with them and their mental health assertive outreach team (AOT). A member of this team said, "Staff will ask appropriately, if they are not sure. They've managed [person] very well". A commissioner had raised concerns to us about one person's care, prior to and during our inspection. We reviewed this person's care records and spoke with an external professional who knew them well. They had no concerns about the care provided and emphasised how well it was working for the person. We found the service was working closely in agreement with health professionals, including managing the risk of this person's refusal to attend booked GP appointments.

Good

Is the service caring?

Our findings

Our conversations with people showed caring relationships had been developed because staff supported the same people regularly. People said, "I've seen [staff member] lots since I was in hospital…They're [all staff] kind… They are proper friends. I don't find them intrusive. I thought I'd have all sorts running in and out but it wasn't like that", "[Staff member] is absolutely brilliant. She listens to what I say. She always asks if I'm OK", "I've got a keyworker. He's going to London with me", "Staff are friendly" and "All the support workers especially [staff member] have got me from not being able to cope, to being able to do things by myself". People also spoke well of an agency staff member who supported them regularly; "Everything you ask isn't too much trouble, he's just put my socks on for me, he's brilliant". Although one of these people said they preferred having permanent staff to agency staff adding, "it's not the same without them".

Attention was given by managers to matching staff with people they worked well with. The staff member responsible for rotas was involved in staff interviews and then sought feedback from staff and the people they supported, during induction, to check how things had gone. Experienced staff were allocated to support people with the most complex needs. Staff knew the people they supported very well. They understood their backgrounds, life histories and interests and described how they worked with people to meet their individual needs. This information was reflected in people's care records. Records also demonstrated that staff were sensitive to people's daily mood fluctuations and changing support needs and responded to these. Staff were positive about their relationships with the people they supported and proud about things they had helped them achieve. For example, a staff member was delighted that a person could now remember their name. They said, "When it started happening I got really excited. We are around the same age so we get on really well".

A staff member told us a person they supported had recently had their support hours reduced after the person told commissioners their family did more for them than they physically could. Despite the reduced hours, the staff member wanted to meet the person's needs. They said, "To try and get everything done it's rush, rush, the sweat's dripping off me… I go five minutes early, in my own time, to run to the shop for [person], I cannot see them go without a cup of tea in the morning". They told us the registered manager planned to speak with the person's relative to resolve this.

People were present for the whole of their care reviews, wherever possible. Their participation was recorded in their care plan, along with their feedback about what was important to them. Comments from people included, "[Staff member] is brilliant. She listens to what I say" and "When they write the notes they ask how I'm feeling. They put down what I say. I do it [care plan] with them". People's decisions and choices were respected even if their decisions were considered unwise. For example, one person regularly smoked in bed and was supported by staff to manage the risk in collaboration with the Fire Service. A member of the management team said, "They [staff] have good working relationships with clients [people], they know them, speak to them respectfully, give them chances and don't assume anything".

We saw that people were comfortable to tell staff what they wanted. Staff checked people had what they needed and offered alternatives when assisting them. People were supported to spend their time where and

how they preferred. People told us they had been involved in making decisions about their care, they felt listened to and that their opinion mattered. People's preferences and wishes were recorded in their care record. When people were less able to speak for themselves, their close relatives or advocate had been involved. People's support plans described their cultural or spiritual needs and how they wished these to be met. People who lived in a shared house were supported with house meetings, so they could air their views about life in the house.

People's privacy and dignity was respected and promoted. Staff gave us examples of how they respected people's privacy and dignity when providing care and support. This was confirmed by our conversations with people. People were supported to maintain independence. We observed staff giving prompts to people to maintain personal care tasks such as eating and drinking. People's support plans detailed areas they needed support with and activities they could manage for themselves. One person who had several visits from staff every day said, "I feel in control. I'm a fairly independent sort of a person". A staff member told us how they worked with another person to ensure they could follow their faith. For example, by lowering and opening window blinds at their home for them at different times of the year.

Good

Is the service responsive?

Our findings

People received care that was personalised and responsive to their needs. A holistic approach to care was taken which included the person's background, health needs and their view about how their life could be improved. For example, their assessment included important recent life events, activities and relationships the person valued and the person's main concerns or difficulties. Where people were unable to provide this information for themselves, staff contacted people's representatives and used their feedback when planning care and support. This ensured the person's view and interests were central to discussions and decision-making about their ongoing care and support needs.

The service worked flexibly around people's individual needs. People's wishes and preferences were noted in their care plans which were reviewed and updated to reflect changes. A staff member told us they were reviewing one person's care plan with them in stages. This was to enable the person to participate fully, as their needs were complex and discussing everything in one meeting would be more than the person could manage. The person said about their care plan, "I'm due another more updated one soon. Because I'm very complex only certain support workers can come here. I've got a structure". Their care plan included their wish to be supported by female staff only; they said this request was always respected. Staff were able to describe people's life history, preferences and characters in detail. This included small things such as the way one person liked their washing to be done, to their choices of television programmes, types of wine preferences, fears and dislikes.

Staff supported people to achieve goals that were important and meaningful to them. For example, records showed that prior to being supported by Dynavour, one person had been hospitalised for a long time and had been considered as having few prospects of re-ablement: They had been accommodated with the service under a best interests decision. Staff enabled this person to return to their passion of cycling and to fulfil a life-long wish of learning to ballroom dance, before progressive illness limited their ability to participate in these activities. The registered manager had also written letters seeking grants for funding a dancing holiday on behalf of this person. Staff corresponded with the person's family on their behalf to share their achievements and enjoyment with them. Their relative said, "It's the best place for [relative] to be with his care".

People were supported to maintain relationships with their friends and family and to follow their personal interests. One person said, "In six years they've got me to where I am now…. They've got me more motivated and they try to make me more independent". For example, staff had assisted them to apply for mobility allowance, which meant they had been able to buy a car and could now drive themselves to the shops and to visit their relatives. They also benefitted from being able to use their support hours flexibility to suit their needs: "If I'm going to my Auntie's for a party I will save my hours up. My family are miles away. It works out well for me". They told us staff supported them while they were in hospital, caring for their pets, doing their washing and visiting them there. They added. "If I've got something wrong they sort it all out". Another person had recently moved back into community life from long-term hospitalisation; an external professional said about them, "[Person's] had a few wobbles but has been very well supported by staff who've helped her to keep in touch with family and also helped with benefits".

The provider worked closely with other community based organisations to signpost people to local sources of support available to them. This included Severn and Wye Recovery College where, for example, people could learn skills to help them manage and recover from mental illness; Artlift - where people were assisted to connect and communicate with others within the group and with their own social networks, through creative arts. One person told us they had been making collages at Artlift each week which they had given to specific staff members. They said, "[Staff member] was really touched by it". Other people used day services including Kingfisher Treasure Seekers. This organisation was set up to enhance the lives of disadvantaged and vulnerable adults and teens, including adults with learning difficulties and disabilities and marginalised and struggling individuals. 'Kingfisher' also regularly visited a shared house, where five people with complex needs lived together, supported by Dynavour staff. The registered manager told us this helped improve people's quality of life and helped them connect with others through group work, establishing relationships and having a good time. A staff member said about one of the people living at this house, "He's doing amazing from when he arrived, he was reclusive with long hair, he's come on so much… It's persuasion all the time with him". Staff persuaded this person by engaging them and making sure activities were rewarding and meaningful to them.

The service had not received any complaints regarding provision of personal care to people in the year prior to our inspection. A complaint about noise from a neighbour was responded to promptly, resulting in the person being admitted for hospital care with an acute episode of mental illness. Two compliments relating to personal care had been received in this period. People were clear about how they would raise a concern or complaint and they told us they would feel comfortable about doing this. Clear information about making complaints, raising concerns or complements was included in the provider's 'Easy Read Service User Guide'. Complaints were encouraged and the guide included contact information for external agencies and advocacy services. Each person had a copy of the guide in their care file. People told us they had no complaints but would be happy to tell staff or the registered manager if they had any problems. Comments from people and their relatives included; "I'm happy here" and "It's a nice relaxed environment, the staff are friendly. If [relative] had any problems he would say".

The registered manager and their deputy were routinely involved in people's care reviews. One said, "We are both doing hands on work, we get to know the clients and staff see you working alongside them". This contact afforded people and staff regular opportunities to speak to managers about their care or any concerns they had. Records demonstrated that when one person had said they didn't always feel listened to, in a care review, manager's responded by introducing them to advocacy services to help them express themselves. Questionnaires had been sent to people in November 2015 to get more formal feedback. The registered manager told us actions arising from this would go into the business plan, which they were working on at the time of the inspection.

Good

Is the service well-led?

Our findings

People benefitted from an open and inclusive culture where the provider's management team were highly visible and had formed strong links with the local community. Staff worked in accordance with the provider's philosophy of care which stated, "We believe that being person centred is more than just using new words. Current policy is about working in new ways that genuinely put the people we are working with at the centre of decision making about their life, and the services and supports they want and need". This person compared their experience of being supported by Dynavour with the negative experience they had of their previous domiciliary care provider, saying, "Oh God, this is completely different".

For example, we saw that people were routinely signposted to, or supported to access, facilities in their local community which helped them recover from illness, learn new skills or cope better with the problems they lived with. An external professional said, "I think they have a very positive view toward people… They are flexible", which in their experience, had a positive impact on people's well-being. For example, a person whose care we tracked had been enabled to move out of long-term secure hospital care, which was a controlled environment, to living in the community where they had a much higher level of personal freedom and choice. This was partly because the provider's sister company was willing to offer the person the security of a long-term tenancy agreement, but also due to the way staff successfully supported the person to cope with "such a big change" in their life. They added, "They have supported her really well through that time, both emotionally and ensuring her practical needs are met". The move had been a significant and potentially overwhelming change for the person. Records confirmed how well this person had settled and the independence they now enjoyed. For example, they frequently went into town with another person who used the service. The person said, "It's a very nice place. I don't think I'd have got anything better than this".

Staff enjoyed working for Dynavour and were motivated in caring for people. They had no concerns about the care they provided. Their comments included, "Dynavour had a very good reputation, that's why I came over to work for them", "I'm quite happy… They're not a bad company". One said about a person they supported, "[Person] has done fantastically well, though her hard work and ours".

The service had a registered manager who notified the Care Quality Commission (CQC) of important events affecting people using the service as required. People and their relatives knew who the registered manager was and were confident they knew what was happening on a day to day basis. On person said, "She's one in a million, you could never replace her… I can get hold of her if I need her". A relative said, "She calls every month, we have a natter". Staff could speak openly with the registered manager and go to the management team at any time with any questions or for advice. They spoke highly of each over and complemented their colleagues, for example, describing them as doing "a fantastic job". One said, "[Registered manager] is very supportive of my personal situation. We have lots of communication, we don't necessarily agree. It can be heated but we get to a middle ground. I'm never afraid to say what I think". Staff told us they voiced their opinions at staff meetings but would not wait for a staff meeting to raise their concerns. Staff were aware of the provider's whistleblowing policy and were clear about their roles and responsibilities and the roles and responsibilities of their colleagues.

The provider's three directors had distinct individual roles which they carried out across Dynavour and its sister companies. The registered manager was responsible for clinical leadership at Dynavour and day to day management of the service, they reported to the main share-holder. The registered manager described them as supportive and accessible. The registered manager told us about the provider's future plans for development of the service and suggestions they had taken to directors, including staff apprentices and renegotiating staff wages to improve the quality of recruitment candidates. This and a staff recruitment incentive scheme, already in place, demonstrated a proactive response to the staff recruitment difficulties the service was currently experiencing. An external professional said, "[Registered manager] is really good… She communicates very well and is very experienced… and is creative in her approach". The service has a good reputation"

The registered manager sought external feedback about staff performance, progress with learning and quality of the service. This included the following comments, "Thank you for the continued support with clients. It has been lovely working with your team", "excellent level of care", "good consistent service which [person] could trust, this was a major issue for [person]… Good value for money, don't foster dependence, are prompt to respond and communicate". When a commissioner raised concerns about aspects of one person's care, the registered manager acted on these and sought further expertise and feedback from others to help them improve the service.

Staff were involved in improving the quality of the service. The team had recently participated in workshops looking at the five domains inspected by the CQC, identifying what they did well and what they could improve upon. The notes from these sessions reflected what we observed and heard during our inspection: This reflected the management team's open and inclusive approach to staff and people who used the service and demonstrated that oversight and governance of the service was effective. The registered manager was collating feedback from people and health professionals at the time of the inspection. They agreed that improved recording and collation of the quality assurance methods employed by the management team would better evidence their oversight of the service.

The registered manager had an outward facing approach to service development. Their qualifications and experience, including a Master's degree in Social Policy, business and management qualifications and experience as a social worker, meant they were exceptionally well placed in leading the service. They were an active participant in local service development groups including provider engagement meetings. They were published in their field and regularly attended conferences both as a delegate and a speaker. Feedback from GP's about their presentations included "inspirational speaker" and "a powerful presentation". A commissioner said about Dynavour, "They pick up the work and do it". National best practice guidance, legislation and local policies were referenced to set standards of care, for example when reviews of the provider's policies and procedures were undertaken.