# Kent Social Care Professionals Limited

# Surrey SCP

## Inspection report

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Date of inspection visit:
09 January 2017

Date of publication:
26 January 2017

## Ratings

| | |
|---|---|
| Overall rating for this service | Good |

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|---|---|
| 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 was announced and was carried out on 09 January 2017.

Surrey SCP is a domiciliary care agency registered to provide personal care to adults living with physical disabilities or cognitive difficulties in their own homes. Services provided include personal care, respite care, night sitting, live-in, domestic help, shopping, preparation of light meals and companionship on outings and appointments. One hundred and twenty people received care from the agency at the time of our inspection.

There was a registered manager in post who had registered with the Care Quality Commission to manage the service in November 2016. Like registered providers, registered managers 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.

Staff were trained in how to protect people from abuse and harm. They knew how to recognise signs of abuse and how to report any concerns.

Risk assessments were centred on the needs of each individual. They included clear measures to reduce identified risks and guidance for staff to follow to make sure people were protected from harm. Accidents and incidents were recorded and monitored to identify how risks of recurrence could be reduced.

There were enough qualified, skilled and experienced staff to meet people's needs. Staffing levels were calculated according to people's changing needs and travel time was taken into account to reduce lateness of visiting calls. The registered manager followed safe recruitment practices.

Staff were trained in the safe administration of medicines. Records relevant to the administration of medicines were monitored to ensure they were accurately kept and medicines were administered safely to people according to their needs.

Staff knew each person well and understood how to meet their support needs. People told us, "They [care workers] know my father well and understand what he needs and how to talk with him." Each person's needs and personal preferences had been assessed before care and support were provided, and these were continually reviewed. This ensured that the staff could provide care in a way that met people's particular needs and wishes.

Staff had completed the training they needed to care for people in a safe way. They had the opportunity to receive further training specific to the needs of the people they supported, such as in dementia care, catheter care and end of life care. All members of care staff received regular one to one supervision sessions and were scheduled for an annual appraisal.

All care staff and management were trained in the principles of the Mental Capacity Act 2005 (MCA) and were

knowledgeable about the requirements of the legislation.

Staff sought and obtained people's consent before they provided care. When people declined, their wishes were respected and people's refusals were recorded and monitored. Staff supported people with their meals and knew about people's dietary preferences and restrictions.
Relatives told us that staff communicated effectively with their loved ones, responded to their needs promptly and treated them with kindness and respect. Satisfaction surveys and feedback indicated people were very satisfied with how care and support were delivered.
Clear information about the service, the management, the facilities, and how to complain was provided to people. Information was available in a format that met people's needs when they had visual impairment.

People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity.

People were referred to health care professionals when needed and in a timely way. Personal records included people's individual plans of care, likes and dislikes and interests. The staff promoted people's independence and encouraged them to do as much as possible for themselves in order to maintain their skills.

People's care plans were person-centred, reviewed regularly with their participation or their families' involvement when this was appropriate. Care plans were updated when needs changed to ensure these were met by staff in practice.

The management team took account of people's feedback. People's views were sought, considered and acted upon. The provider sent questionnaires regularly to people to obtain their feedback on the quality of the service. Regular quality assurance visits were carried out in people's homes to check that the care delivered met people's needs. The results were analysed and action was taken in response to people's views.

Staff told us they felt valued by the management team and the care coordinators. Their suggestions were taken in consideration by the management team. The registered manager notified the Care Quality Commission of any significant events that affected people or the service. A robust system of audits was carried out to identify how the service could improve, and as a result improvements were implemented to enhance people's experience of the service.

## 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.

Staff were trained in the safeguarding of vulnerable adults and were knowledgeable about recognising the signs of abuse.

Risk assessments were centred on the needs of the individuals and there were sufficient staff on duty to safely meet people's needs.

Thorough staff recruitment procedures were followed in practice. Medicines were administered safely; their administration and relevant documentation were subject to regular reviews.

### Is the service effective?

Good

The service was effective.

All staff had completed essential training to maintain their knowledge and skills.

The provider was meeting the requirements of the Mental Capacity Act 2005.

People were appropriately supported with their nutritional needs.

People were referred to healthcare professionals promptly when required.

### Is the service caring?

Good

The service was caring.

Staff communicated effectively with people, responded to their needs promptly, and treated them with kindness and respect.

Comprehensive information was provided to people about the service and how to complain. People were involved in the planning of their care and support when appropriate.

Staff respected people's privacy and dignity.

The staff promoted people's independence and encouraged people to do as much for themselves as possible.

## Is the service responsive?

Good

The service was responsive.

People's needs were comprehensively assessed before any support was provided. People's care was personalised to reflect their wishes and what was important to them. Care plans and risk assessments were reviewed and updated routinely and when needs changed.

People knew how to complain and people's views were listened to and acted on.

## Is the service well-led?

Good

The service was well-led.

There was an open and positive culture which focussed on people. The provider sought people and staff' feedback and welcomed their suggestions for improvement.

Staff had confidence in the management team and care coordinators' response when they had any concerns.

There was a robust system of quality assurance in place. The management team and the Quality Team carried out audits that covered every aspect of the service to identify where improvements to the service could be made.

# Surrey SCP

**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 was carried out on 09 January 2017 and was an announced inspection. Notice of the inspection was given because we needed to be sure that the managers and staff we needed to speak with were available. The inspection was carried out by one inspector.

The manager had not received a Provider Information Return (PIR) at the time of our visit. The PIR is a form that asks the provider to give some key information about the service, what the service does well and what improvements they plan to make. We gathered this information during our inspection. Before our inspection we looked at records that were sent to us by the registered manager or the local authority to inform us of significant changes and events.

We spoke with 11 people or their relatives to gather their feedback about the care that was provided. We also spoke with the regional director, the regional manager, the registered manager, the branch manager, and five members of staff. We consulted a local authority social worker who oversaw people's welfare while they received support from the service to obtain their feedback.

We looked at records that included seven people's care plans and reviews, risk assessments, and medicines administration records. We consulted six staff files, staff rotas, staff training records, satisfaction surveys, quality assurance checks, audits and sampled the service's policies and procedures.

This was our first inspection since the location was registered with the Care Quality Commission in December 2014.

Good

# Is the service safe?

## Our findings

Relatives told us that their loved ones felt safe when staff provided care and support. They said, "I feel my parents are in safe hands when the care workers are there", "Knowing these care workers go in everyday give me peace of mind, I trust them implicitly" and "My father used to have a lot of falls but since the agency workers go in, this is a thing of the past."

There were sufficient staff on duty to meet people's needs and ensure continuity of care. There were 82 care workers deployed to visit 120 people in their homes. The registered manager was supported with the day to day running of the service by a branch manager, a deputy branch manager, three care co-ordinators and one recruitment officer. Travelling time was appropriately taken into account when staff visits to people's homes were scheduled. When care workers were late in reaching people's home due to unforeseeable circumstances such as heavy traffic, people were informed promptly.

People received a weekly rota in advance so they knew who to expect and at what time. They told us that staff cover was consistently assured when needed due to leave or sickness. A care worker told us, "We are never rushed because we have the time to do what is needed and we often do more than planned if there is any spare time, or chat with people which is just as important."

As staffing levels were increased when necessary, there were enough staff to meet people's individual needs. Care workers were provided in pair when appropriate to keep people safe. Whenever people's needs changed to warrant an increase of their care package, the care coordinators approached individuals to seek their agreement and contacted local authority case managers when appropriate to secure relevant funding. The branch manager told us, "We make sure that changes in care packages are implemented quickly as we need to respond to changes as soon as they occur." For example a care package had been increased to accommodate a person's needs during the end of their life; another had been increased when a person had become unwell.

People's medicines were managed so that they received them safely. The service held a policy for the administration of medicines that was regularly reviewed and up to date. Staff had received appropriate training in the recording, handling, safe keeping, administration and disposal of medicines. This ensured people's medicines were administered by knowledgeable and skilled staff. The level of support that people needed in regard to their medicines was assessed before the care was provided. Depending on the assessed level, medicines reviews were carried out by senior staff in people's homes either weekly, fortnightly or monthly.

People's care plans included clear guidance for staff to follow which the staff understood and used in practice. This included how and when to administer medicines that were prescribed to be taken 'as required'. Staff signed individual Medication Administration Records (MAR) to evidence that people had taken their medicines. Appropriate coding was used to indicate when people refused, were absent or too ill to take their medicines. MAR sheets were brought into the office monthly and were audited by senior staff to check that they were accurately completed.

Staff were trained in recognising the signs of abuse and knew how to refer to the local authority if they had any concerns. They carried the contact details of the local authority safeguarding team in their mobile phones. Staff had made appropriate referrals to the local authority when they had been concerned about people's safety. Staff training records confirmed that their training in the safeguarding of adults was annual and up to date. The members of staff we spoke with demonstrated their knowledge of the procedures to follow to report abuse and they knew how to use the whistle blowing policy should they have any concerns. A member of staff told us they had "Zero tolerance for abuse of any kind; we need to protect vulnerable people."

Recruitment procedures included interview records, checking employment references and carrying out Disclosure and Barring Service (DBS) checks. These checks identified if prospective staff had a criminal record or were barred from working with people who required personal care. Gaps in employment history were explained. All staff received an induction and shadowed more experienced staff until they could demonstrate a satisfactory level of competence to work on their own. They were subject to a probation period before they became permanent members of staff. Disciplinary procedures were followed if any staff behaved outside their code of conduct. This ensured people and their relatives could be assured that staff were of good character and fit to carry out their duties.

Assessments of people's environment were carried out in their homes before staff started to provide care. These included checking the access and exit of properties, and identifying potential hazards such as those associated with pets, stairs, floorings and kitchen appliances. A member of staff had smelled gas in a person's property, had cut off gas at source and called the appropriate authority to ensure the person was safe; a person who smoked tobacco had been referred to the fire service for the installation of smoke detectors in their home. The service referred people to local authority when they needed a safe key storage system to enable easy access, and/or a portable alarm system linked to an emergency service. All equipment that assisted people in their home was regularly checked by occupational therapists to ensure they were safe to use.

Risk assessments were centred on the needs of the individual. They included clear measures to reduce the risks to people and appropriate guidance for staff. For example, risk assessments had been carried out for a person who chose to misuse alcohol; for another person who experienced dizziness and for people who were at risk of falls due to frailty. Control measures were clear and proportionate, including encouragement to moderate alcohol consumption; ensuring that help was provided with carrying any heavy loads; and additional support while moving around. Staff applied the control measures in practice and recorded these in their daily logs.

Accidents and incidents were appropriately recorded and monitored daily by the care coordinators and managers to check whether there were any common triggers that could be further avoided. Events were entered in the service computerised system to trigger a notification to the regional manager and to the provider's Quality Team. The Quality Team audited these notifications every three months. If people had experienced a fall, their environment and the care they received were re-assessed to ensure hazards were identified and reduced.

The landlord ensured that the office premises were secure and the branch manager had carried out a fire risk assessment in November 2016. Evacuation plans were clearly displayed in the office. All staff were trained in first aid and fire awareness and they knew how to respond appropriately to keep people as safe as possible. The provider had an appropriate business contingency plan that addressed possible emergencies such as fire, severe weather, floods and loss of power. The plan included a list of people who used the service and their contact details. In individual care plans, there were details of how people could be

evacuated in the needs of an emergency, the help they would need, and the location of the most suitable exit. There was an on-call system to respond to enquiries during out of hours, managed by the office staff in rotation.

Good

# Is the service effective?

## Our findings

People and relatives' comments were very positive about the service's effectiveness and staff efficiency. They told us, "The care workers seem to be very well trained", "They [care workers] know their stuff, they obviously have had good training, and sometimes they get observed by a manager while they do the work" and, "Whenever I had to call the office because there was a delay, which wasn't often, they put it right and within ten minutes of my call there is care worker at the door." A local authority case manager who oversaw people's welfare in the community told us, "The care workers are very good, they understand safeguarding issues and they report any concerns or any need for an increase in care packages to the office team who gets in touch with us."

Staff had appropriate training and experience to support people with their individual needs. Staff confirmed they had received a comprehensive induction that included studying for the Care Certificate over a period of twelve weeks. This certificate was launched in April 2015 and is designed for new and existing staff, setting out the learning outcomes, competencies and standard of care that domiciliary care agencies are expected to uphold. Staff completed 17 workbooks which were signed off by the branch manager upon satisfactory completion. They had demonstrated their competence before they had been allowed to work on their own.

Essential training was provided annually and further training titled 'Impact' had been introduced to reinforce mandatory training in medicines and mental capacity. Staff had the opportunity to receive further training specific for the needs of people they supported. This included dementia care, skin and stoma care, Parkinson's disease, diabetes, stroke, and end of life care. Other training that had been provided included 'The impact and consequences of getting it wrong', 'Privacy, dignity, independence and choice' and, 'Internal communication, record keeping, care planning and person centred care.' The staff we spoke with were knowledgeable about the specific needs of people they cared for, such as needs relevant to catheter care and pressure areas.

The service participated in the Qualifications and Credit Framework (QCF) programme and supported staff to gain qualifications in health and social care. All care workers were encouraged to enrol in the studies programme and most had gained or studied for diplomas at level two and three. One member of staff who had declined to study had been encouraged to reconsider; a care coordinator had completed a diploma at level five.

All members of care staff received regular one to one supervision sessions that were appropriately documented. At these sessions, a theme was selected such as an aspect of practice, and fictitious scenarios were explored to assess staff knowledge and competence. All staff were scheduled for an annual appraisal. A member of staff told us, "Supervision is useful; I get supervised by a care coordinator who used to do what I do, so she truly understands; I can explain whatever I find problematic and we find solutions together." Staff told us they felt supported in their work and that their rotas offered some flexibility taking into account family commitments. Care workers attended monthly 'drop-in sessions' to meet each other in a social setting, gain peer support and exchange experience or points of view. This reduced care workers' isolation when they were lone working.

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. We checked whether the service was working within the principles of the MCA and discussed the requirements of the Mental Capacity Act (MCA) 2005 with the management team. They demonstrated a good understanding of the process to follow when people did not have the mental capacity required to make certain decisions. Staff were trained in the principles of the MCA and were knowledgeable about the requirements of the legislation. A suitable template was in place to enable staff to assess people's mental capacity for less complex decisions, for example whether or not to accept assistance with personal care or the administration of medicines. However, an assessment of mental capacity had not been warranted to date and we discussed with the management team how their system could be further embedded in practice should the need arise. The registered manager had participated in meetings with local authority where more complex decisions needed to be made in people's best interests.

Staff sought and obtained people's consent before they helped them. One relative told us, "All the workers check that my husband wants them to step in before they do so." A person who used the service told us, "If I say 'no' they just don't do it; it is that simple."

Staff prepared and served light meals for people, using people's food or after having purchased groceries on their behalf. Staff were made aware of people's allergies, food preferences and dislikes. A member of staff told us how two people disliked potatoes and pasta; another liked liver and cabbage. One person told us, "They know what I like, they open my fridge and say 'What would you fancy today?' and they cook it the way I like, always presenting it nicely on a plate." One person had a gluten-free diet; another person who had difficulties swallowing had been referred to a dietician while staff followed a GP's recommendations and thickened their fluids.

Referrals to health care professionals and other services were appropriately made and followed up. For example, staff had contacted district nurses to source a specialised mattress to preserve a person's skin integrity; and occupational therapists for the assessment and provision of equipment in people's homes. When staff noticed people were losing weight, they discussed with them the option of getting medical advice and a check-up, and contacted their GP on their behalf when appropriate. Emergency services were appropriately called if people became severely unwell.

Good

# Is the service caring?

## Our findings

People and their relatives told us they were satisfied with the way staff delivered care and support. Their comments included, "The workers are ever so caring, they are kind, patient, reliable, really lovely people", "I could not have better people coming to help me" and, "You could not find more caring people, the carers are like friends to us; we have known them and they have known us for several years through thick and thin; lovely people." Two relatives had complimented the service stating, "In the early days you were just a voice at the end of the phone, answering my practical problems, then as mum's dementia got worse you became the voice who was always there, who knew mum and was able to tell me things about her everyday problems I didn't know" and, "I found all the care workers to be friendly, efficient and professional."

Positive caring relationships were developed by staff with people who used the service. All the people and relatives we spoke with told us how care workers engaged positively with respectful attitude and appropriate humour. Staff told us they valued the people they visited and spent time talking with them while they provided care and support. Two care workers told us, "The human contact is so important when you realise so many people feel lonely or isolated, we could be the only person they see all day and we must make that count" and, "I feel useful doing this job; I can make a difference in people's lives." Care plans included instructions for staff to follow when people needed companionship, such as sitting with them for a cup of tea and a chat after their had completed their tasks.

Care workers were matched with individuals after their personalities and interests were taken into consideration. A local authority social worker who oversaw people's welfare in the community told us, "People develop good relationships with the agency staff; the staff are caring and not rushed." The service ensured that same workers were allocated to individuals as much as possible. New care workers received a comprehensive handover before they were introduced to people and before they started delivering care.

People commented on how well the staff communicated with them. Specific methods of communication were clearly indicated in people's care plans and implemented in practice. A person who had difficulties with verbal communication used a booklet that contained images and words to communicate with staff; another person had a hearing impairment and staff were instructed to speak loudly, slowly and clearly, maintaining positive eye contact and ensuring they were understood. Their relative told us, "They take their time to talk with [X] having to repeat several times and they are very patient."

Information was provided to people in the form of a leaflet and a small brochure, introducing the services available, displaying photographs and the working experience of the management team, details of staff training and the system in place to track staff and ensure calls were not delayed or missed. New leaflets were in the process of being drafted, to reflect updates in the service and its team. When a person's care package started, people were provided with a 'service user guide', available in a larger print format or Braille, to assist people with visual impairment. The guide was comprehensive and addressed all aspects of the service including how to lodge a complaint.

People had a folder in their home which contained an updated care plan, daily notes, medicines

administration records, and who to contact if the care worker had not arrived on time. The provider circulated a seasonal group newsletter to each sub-organisation and each branch produced an internal newsletter for staff that included updates and accounts of good practice.

Attention was paid to equality and diversity. A person had limited use of English and a care coordinator of the same nationality had been selected to coordinate their care package. When people had expressed their religious beliefs or requirements, these were included in their care plans. One person was visited monthly by a vicar and this was recorded as this was important to them; another person had stated having strong religious beliefs and staff were aware of their faith.

Staff were made aware of people's likes and dislikes to ensure the support they provided was informed by people's preferences. All the care plans that we looked at included people's individual preferences, likes and dislikes. For example, a person liked to play computer games to keep their mind alert and exercise their hands; another person liked a particular routine to be followed during their personal care; another enjoyed watching people from their window, watching television and listening to music. Staff we spoke with were aware of these individual preferences.

Explanations were provided by staff to people appropriately. For example, when care workers helped a person with their personal care. Their relative told us that staff kept talking with the person and explained every step of their intervention beforehand. A relative told us, "The workers always warn me before they operate the hoist and lift me so I don't get surprised; they talk to me while they transfer me from one place to another, when they are about to lower me, and when they have finished." This caring approach ensured people were involved in the delivery of their care and support as explanations were provided.

The staff held information about advocacy services and followed guidance that was provided by the local authority. A system for referring people to advocates was in place. An advocate can help people express their views when no one else is available to assist them. However there had been no cause to use this service at the time of our inspection.

People's privacy was respected and people were assisted with their personal care needs in a way that respected their dignity. The staff had received training in respecting people's privacy, dignity and confidentiality. Staff we spoke with told us they closed curtains and/or closed doors when they helped people with personal care, ensuring they were not exposed unnecessarily to preserve their privacy and dignity. A person confirmed to us that staff ensured their privacy and dignity was respected, telling us, "They understand I can be a little self-conscious and they are so lovely about it, they are very discreet." This meant that people were assured that they were cared for by sensitive staff who paid attention to their feelings.

Staff promoted people's independence and encouraged people to do as much as possible for themselves. They accompanied people to a Cafeteria, escorted them to watch aeroplanes in the local airport grounds where the office was situated, or went shopping with them when this was included in their care plans. Staff ensured a person who had experienced a fall and who was in a period of rehabilitation was encouraged to use their walking aid and walk independently with some supervision. A care worker told us, "It's all about getting the skills going, if skills are not used they get lost so people have to maintain their skills as much as possible for as long as possible." The registered manager told us, "We aim to enable people to remain in their own home when this is what they wish, and to that effect our role is to promote their independence , providing whatever support they may need."

Good

# Is the service responsive?

## Our findings

People received care and support that was responsive to their individual needs. Relatives told us, "I like the staff; they know my father well and understand what he needs and how to talk with him", "I am involved with reviews of my parents' care, actually there is one review scheduled tomorrow so we can have a look at the care plans together and see if we need to change anything" and, "There is flexibility, for example over Christmas we had to change the times at short notice and they did all the changes with no problem at all." Two relatives had complimented the service stating, "You have been so patient; you had to answer mum calling you ten times at night" and, "You were instrumental in getting more and more care [funding] from Social Services, I simply would not have achieved this without you." A person told us, "I need a lot of time to get out of bed and they know this, we have created a nice little routine and they know exactly what I like."

Comprehensive assessments of needs and risk were carried out before the care and support were provided. This included needs relevant to people's mobility, health, communication, likes and dislikes and interests. These assessments were carried out in their homes or in hospitals by senior staff and care coordinators. The service also took account of assessments of needs provided by the local authority. Within 48 hours, individualised care plans were produced and these were updated as the care package progressed.

Care plans were developed with people and/or their legal representatives' involvement, and included specific requests about how they wished to have their care provided at specific times of day or night. People's care was planned taking account of their preferences and what was important to them, such as the goals they wished to achieve and their favoured routines. One person experienced a weakness in a limb and as a result, a care plan had been developed with them to instruct staff about meal preparation, the administration of medicines and the application of topical cream. A person had expressed the wish to have only female workers; another wished not to be disturbed until mid-morning; another wished for their dog to be taken for a daily walk. These wishes were respected in practice. Some of the staff had been trained in catheter and stoma site care so they could meet people's such specific needs. A care worker told us, "We know about specific requirements, and we often go above the care plan, doing a bit more when we can, because everyone needs a bit of extra help."

People's individual assessments and care plans were reviewed yearly or sooner if needs changed. They were updated appropriately to reflect any changes. People, and their relatives when they had consented to this, were informed in advance when reviews of their care plan were scheduled. This ensured people were able to think ahead about any changes they may wish to implement. The branch manager told us, "We sit with people in their home to do the reviews and go through everything together, to make sure that we don't miss any changes of need or any new preference." A person who received support told us, "They do what I ask them to do, often more". A relative told us how staff had responded to their loved one's needs and changed their visiting times when they had felt unwell.

The provider had a complaints policy and procedure that had been reviewed in October 2016. Eight complaints, expressed either verbally or in a written form, had been lodged in the last twelve months, which had been addressed appropriately as per the service complaint policy. The registered manager and regional

manager audited complaints quarterly to identify any common triggers and patterns.

People's views were sought, considered and acted upon. People's feedback was collected shortly after the provision of care had begun and at each review of the care plans. Additional 'quality assurance visits' were carried out every three months, at which people's feedback was sought and recorded. The registered manager told us, "As we communicate well with people who use the service, we get to know very quickly if any improvement to the care package needs to be made and we do it." All feedback that we collected was positive about all aspects of the service.

Comprehensive questionnaires were sent annually to people and their families, seeking their views on the service. There was a system in place to ensure these views were acted on when improvements to people's experience needed to be made. The last survey dated May 2016 and the completed questionnaires were sent to the provider's Quality Team to be audited. The findings of the audit were forwarded to the regional, registered, and branch managers. The deputy manager who oversaw the quality administration system scrutinised the findings with the branch manager and wrote an action plan which was revisited at each office meeting. At the last survey, some people had expressed the wish to be contacted promptly whenever care workers were running late, and as a result staff had been reminded of this at the next staff team meeting. The Quality Team also contacted four care workers and four people who used the service every three months to collect their overall feedback. The findings were included in their quarterly internal audits. The provider also carried out a yearly staff satisfaction survey. The results of the last survey in 2016 where 22 staff had chosen to participate had been discussed at team meetings and had indicated a high level of overall satisfaction.

Good

# Is the service well-led?

## Our findings

Our discussions with relatives, the registered manager and staff showed us that there was an open and positive culture that focussed on people. A relative told us, "Whenever I called the office there was always someone on the phone to sort everything out, they are very reliable even at weekends", "You can tell that older people matter to them, they put them first, they genuinely care" and, "This is a good organisation, there is always someone to call you back and follow up any queries, to visit you, to explain whatever needs to be explained; it is obviously well managed." A relative had complimented the service stating, "The support I received from the office is exemplary, extremely helpful and pertinent."

Members of staff were welcome to come into the office to speak with the management team at any time. Members of staff confirmed that they had confidence in the care coordinators and in the management team. They told us they found the care coordinators who provided one to one support, "Really good, very understanding" and, "Supportive; they give us the flexibility to do the job as it should be done." The newly registered manager had been in post since October 2016 and spent three days a week in the service, as they divided their time with another service. Staff approached them and the branch manager regarding the day to day running of the service, whom they described as, "Very efficient and knowledgeable" and, "Supportive, also very knowledgeable about each client."

Staff had easy access to the policies and procedures that were continually reviewed and updated by the provider. Attention was paid to new legislation that could affect the service. When policy updates had taken place, all staff had been informed at team meetings and in a quarterly newsletter. This system ensured that the staff were aware of procedures to follow and of the standards of work expected of them to provide safe, effective, responsive care and support for people. There was a lead in medicines and staff became dignity champions when they had evidenced high standards of practice.

Management meetings were held regularly to ensure good internal and external communication and address the day to day running of the service. Every six weeks, the regional manager and registered manager met with the branch manager; at these meetings, the Quality Team was invited and the regional manager carried out a presentation on diverse topics such as investigations of complaints. Every month, the registered manager met with the branch manager; the registered manager met with all office staff every quarterly; and the branch manager met with all staff quarterly. All meetings were minuted and when necessary, an action plan was written that was monitored until completion.

Staff suggestions were taken in consideration about the service was run. At a recent team meeting a care worker had suggested more time to be spent with new recruited staff going through people's care plans; another had suggested sourcing books for people with dementia. As a result of these suggestions, care coordinators sat with new recruited staff for an hour in the office discussing individual care plans; the branch manager had joined the library and organised a regular delivery of books to some people's homes, that were suitable for people living with dementia.

The managers, care coordinators, and the compliance and quality staff received enhanced training in the

use of the computerised system, about notifications, staff supervision, appraisals and team meetings. The registered manager attended a forum organised by a local care association to meet other managers, exchange ideas and discuss management practice. The regional director and the regional manager met other directors and managers from sister services at Head Office every month.

A robust system of quality assurance checks was in place and implemented to drive improvements in the service. As well as regular reviews of people's care plans, quarterly 'Quality assurance visits' were carried out in people's homes to review how care was provided, any changes of needs or risks, and identify whether additional resources were needed. The Quality Team inspected the service every three months and checked every aspect of the service against the requirements of the Health and Social Care Act 2008. They produced a report which was analysed by a management team including the registered manager, branch manager, deputy branch manager, the care coordinators and the recruitment officer. An action plan was written when shortfalls had been identified. As a result of an action plan, staff files had been updated, and informative posters about care practice had been displayed in the training room. These summarised procedures about safeguarding, pressure ulcers, mental capacity, nutrition and hydration, privacy and continence.

The deputy manager audited all daily log notes and had identified a need for improvement regarding the way people's food intake was recorded; how people's skin integrity was monitored; and how financial transactions were recorded by staff. These improvements had been implemented. In addition, the regional manager inspected several aspects of the service in rotation. Their monthly reports addressed care planning documentation, risk assessments, quality assurance visits, complaints, staff spot checks, supervision, appraisals and training. Findings were inputted in the computerised system which generated a statistic of compliance with regulations. The last report indicated a compliance rate of 97%. They told us, "Any rate below 90% triggers a flagging system and we take action, reporting to our Quality Team. When they wrote an action plan, this was implemented by the registered manager and branch manager, and monitored until completion.

The registered manager spoke to us about their vision and values about the service. They told us, "We focus on the quality of the service; we want people to maintain their independence as much as possible in their own homes while preserving their freedom of choice and their dignity." The regional manager told us, "We do apply the 'Mum test' and ask ourselves and our staff: would we be happy for your own parents to receive care from us? This is a good reminder of the quality of care we strive to deliver." The provider's values were, 'We care; we listen; we strive; we build.' The feedback we collected indicated that staff followed this philosophy in practice.

The registered manager consistently notified the Care Quality Commission of any significant events that affected people or the service. The manager took part in safeguarding meetings with the local authority when appropriate to discuss how to keep people safe and kept families involved in decisions concerning their family members' safety and welfare.

People's records were kept securely. Archived records were labelled, dated and stored in a dedicated space. They were disposed of safely. All computerised data was password protected to ensure only authorised staff could access these records. The computerised data was backed-up by external systems to ensure vital information about people could be retrieved promptly.