Able Care and Support Services Ltd

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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

This inspection took place on 12 and 19 October 2016 and was announced. This was to ensure someone would be available to speak with us and show us records. We visited the provider's office on 12 October 2016, and spoke with people who used the service, family members and staff on 19 October 2016.

Able Care and Support Services Limited provides care and support to people in their own homes. On the day of our inspection there were 24 people using the service.

The service had a registered manager in place. A registered manager is a person who has registered with the Care Quality Commission (CQC) 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.

Able Care and Support Services Limited was last inspected by CQC on 11 June 2013 and was compliant with the regulations in force at that time.

Processes were in place to record and investigate accidents and incidents. Management and staff were aware of their responsibilities with regard to safeguarding vulnerable people and appropriate policies and procedures were in place. Risk assessments described potential risks and the safeguards in place to protect people who used the service and staff. Appropriate arrangements were in place for the administration and storage of medicines.

Staff were suitably trained and received regular supervisions and appraisals. The registered provider had an effective recruitment and selection procedure in place and carried out relevant pre-employment checks when they were recruiting staff.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

People were protected from the risk of poor nutrition and staff were aware of people's nutritional needs. Care records contained evidence of visits to and from external health care specialists.

People who used the service, and family members, were highly complementary about the standard of care provided by Able Care and Support Services Limited. Care was planned and delivered in a way that was personalised to each person.

People's end of life care needs were catered for and staff were trained in how to provide end of life care. Staff treated people with dignity and respect and helped to maintain people's independence by encouraging them to care for themselves where possible.

Care records indicated that people's needs were assessed before they started using the service and care

plans were written in a person centred way. Staff sought alternative methods in supporting people with their care needs and went the extra mile when providing care and support.

Staff were aware of people's interests and hobbies and people were protected from social isolation. People who used the service, and family members, were aware of how to make a complaint and no formal complaints had been recorded at the service.

Staff felt supported by the registered manager and were comfortable raising any concerns. People who used the service, family members and staff were regularly consulted about the quality of the service. Family members told us they could contact the management at any time and the management were approachable and understanding.

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.

Risk assessments were in place for people and staff and accidents and incidents were appropriately recorded and investigated.

Staffing levels were appropriate to meet the needs of people who used the service and the registered provider had an effective recruitment and selection procedure in place.

The registered manager was aware of their responsibilities with regards to safeguarding and staff had been trained in how to protect vulnerable adults.

Procedures were in place to ensure people received medicines as prescribed.

Is the service effective?

Good

The service was effective.

Staff were fully supported in their role. They received regular supervisions and appraisals and their training was up to date.

Staff were aware of people's nutritional needs and food and drink preferences, and supported people at mealtimes.

People had access to healthcare services and received ongoing healthcare support.

The registered provider was working within the principles of the Mental Capacity Act 2005 (MCA).

Is the service caring?

Good

The service was caring.

Staff were aware of the individual needs of people who used the service.

Staff treated people with dignity and respect and dignity was at

the heart of the care provided.

Staff were trained to care for people with palliative care needs and provided support to people at their end of life.

People had been involved in writing their care plans and their wishes were taken into consideration.

Is the service responsive?

Good

The service was responsive.

People's needs were assessed before they started using the service and care plans were written in a person centred way.

People were supported to access the community, appointments and other social events.

The registered provider had an effective complaints policy and procedure in place and people knew how to make a complaint.

Is the service well-led?

Good

The service was well-led.

The service had a positive culture that was person-centred, open and inclusive.

The registered provider had a robust quality assurance system in place and gathered information about the quality of their service from a variety of sources.

Staff told us the registered manager was approachable and they felt supported in their role.

Able Care and Support Services Ltd

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 registered provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

This inspection took place on 12 and 19 October 2016 and was announced. This was to ensure someone would be available to speak with us and show us records. One Adult Social Care inspector took part in this inspection.

Before we visited the service we checked the information we held about this location and the service provider, for example, inspection history, safeguarding notifications and complaints. We also contacted professionals involved in caring for people who used the service, including commissioners and safeguarding staff. Information provided by these professionals was used to inform the inspection.

Before the inspection, the registered provider completed a Provider Information Return (PIR). This is a form that asks the registered provider to give some key information about the service, what the service does well and improvements they plan to make. We used this information to inform our inspection.

During our inspection we spoke with two people who used the service, three family members and a healthcare professional. We also spoke with the registered manager, operations manager, enablement manager and two members of staff.

We looked at the personal care or treatment records of three people who used the service and observed how people were being cared for. We also looked at the personnel files for three members of staff and records relating to the management of the service, such as quality audits, policies and procedures.

Good

Is the service safe?

Our findings

Family members we spoke with told us they thought their relatives were safe with Able Care and Support Services Limited. They told us, "I know he's safe and I can rely on them. If anything happens they tell me straight away. It is reassuring" and "Safe? Absolutely".

We looked at staff recruitment records and saw that appropriate checks had been undertaken before staff began working for the service. Disclosure and Barring Service (DBS) checks were carried out and at least two written references were obtained, including one from the staff member's previous employer. The registered manager told us that they recently increased the number of reference requests to four to ensure they received a satisfactory number back. The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults. This helps employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults. Proof of identity was obtained from each member of staff, including copies of passports, driving licences and birth certificates. We also saw copies of application forms and these were checked to ensure that personal details were correct and that any gaps in employment history had been suitably explained. This meant the registered provider had an effective recruitment and selection procedure in place and carried out relevant checks when they employed staff.

We discussed staffing levels with the registered manager. Staff completed a shift availability sheet during recruitment to say which week days they would be available to work, the duration they were available for and the area in which they could work. The registered manager told us agency staff were not used and any absences were covered by the registered provider's own permanent staff. People who used told us they saw familiar staff and always knew who was visiting. Family members told us, "I always know which girls I'm getting. They have the same people doing the visits" and "He knows them all when they come". This meant there were enough staff with the right experience and knowledge to meet the needs of the people who used the service.

Service user risk assessments were in place for people who used the service and staff. These included the environment, tasks carried out by care staff, moving and positioning, electrical and gas appliances, control of substances hazardous to health (COSHH), fire safety, external environment, lone working and medication. Any identified risks were included on a "Hazards identified" sheet, which recorded the risk, action taken to reduce the risk and person responsible for reducing the risk. For example, a risk to lone workers was identified as the time of the call meant there may be people leaving a local public house. Staff were advised to be aware of people approaching them. The registered provider had a lone working policy in place which was designed to alert staff to the risk presented by lone working. The registered manager told us each member of staff was provided with a utility bag, which includes an emergency alarm and torch, a first aid kit, mouth guards for Cardio Pulmonary Resuscitation (CPR) and hand gel. The provider operated a live on call system staffed by management and was in the process of implementing an electronic call monitoring system.

Additional moving and handling assessments had been carried out and moving and handling plans were in

place, which described the moving and handling task, equipment or procedure to be used by care staff and any other relevant information required to mobilise the person safely.

People had infection control plans in place to reduce the risk of exposure to infection. The registered provider had an infection control policy in place which provided guidance on staff responsibilities, causes and the spread of infection, and standard principles for infection prevention and control. Staff were trained in health and safety and infection control, and checks were carried out to ensure staff were following procedures and wearing the appropriate personal protective equipment (PPE). Care records described the procedures staff were to follow when carrying out personal care, including hand washing, use of PPE and use of waste bags for soiled clothing.

Personal emergency evacuation plans were in place for each person who used the service, which described the procedure for staff to follow in the event of a fire. This meant the registered provider had taken seriously any risks to people and put in place actions to help prevent accidents from occurring.

We saw a copy of the registered provider's safeguarding policy, which had been adopted from the local authority adults safeguarding partnership. Procedures were in place for the reporting and recording of any safeguarding or alleged safeguarding incidents. The safeguarding file contained a certificate of attendance on the safeguarding adults manager's training course by the enablement manager, copies of local authority safeguarding policies and procedures, and safeguarding referral forms. We discussed safeguarding with the registered manager who told us there had not been any safeguarding incidents at the service. Management and staff were aware of their responsibilities and staff were appropriately trained in protecting vulnerable people.

Copies of accident and incident forms were in people's care records and recorded the date and time of the accident or incident, who was involved, details of any witnesses and a description of the accident or incident. A Health and Safety Executive (HSE) accident book was also maintained by the registered manager. The registered manager monitored and reviewed any accidents or incidents that had occurred involving staff and people who used the service.

We looked at the management of medicines and saw the registered provider's medication policy was devised by the United Kingdom Home Care Association (UKHCA) for the registered provider, which outlined the requirements of staff regarding the administration of medicines. Procedures in support of the policy were in place and included assistance with medication, communication, obtaining consent, covert medication, PRN or as and when required medicines, obtaining prescriptions, the disposal of medicines, and controlled drugs. Controlled drugs are drugs that may be at risk of misuse.

Staff received training in medicines during their induction and training in the prompting, assisting and administering of medicines as part of their mandatory training.

Medication administration competency forms were completed for staff on a regular basis and checked whether staff followed the correct procedures, including use of PPE, checking of the medication administration record (MAR), whether the staff followed the correct administration of medicine procedure, communication with the person, storage of medicines and the correct recording of information on the MAR. A MAR is a document showing the medicines a person has been prescribed and recording when they have been administered.

Care records included a list of prescribed medication and included the name of the medication, the time of day (including whether it was PRN medication) and the dose. Care records also included a medication

information leaflet, which described the medicine, what it was used for, possible side effects and storage information.

We looked at completed MARs from September 2016 and saw they had been appropriately completed and audited by management. Additional controlled drug MARs were in place as required. Controlled drug audit books were completed each time a controlled drug was administered and included the date, time of administration, amount carried forward, amount dispensed, balance and staff signature.

Medicines were stored securely in people's own homes. Controlled drugs were locked and secure at people's homes in safes or safety deposit boxes.

This meant appropriate arrangements were in place for the administration and storage of medicines.

Good

Is the service effective?

Our findings

People who used the service received effective care and support from well trained and well supported staff. People told us they were well looked after. Family members told us, "Absolutely brilliant. He's never looked back. It's been brilliant. He's well looked after", "All the girls and the men are absolutely brilliant with him. He gets on well with them", "I have nothing but praise for them. They are brilliant", "They really care about the people. They bend over backwards to help people" and "They are all absolutely fabulous".

Staff received mandatory training in food safety, emergency first aid, dementia, tissue viability, mental capacity, infection control, health and safety, fire, moving and positioning, medicine administration and safeguarding. Mandatory training is training that the registered provider thinks is necessary to support people safely. Staff were required to attend updates on their training every one to three years depending on the course. Staff also received training in other areas depending on the people they supported. For example, behaviour that challenges, end of life and tissue viability. Staff we spoke with told us, "Yes we get a lot of training" and "If there's anything else we want to do, we ask and [registered manager] will source it."

The registered manager, operations manager and enablement manager were qualified trainers and trained staff in several health and social care courses, including the staff induction, dignity, moving and positioning, health and safety, food safety and medicines. The registered provider had their own training facilities at their office location. Other training was completed on line but the registered manager told us courses were specifically selected and included an exam at the end of each one to ensure staff understood the subject. Records of staff training were uploaded on to the national minimum data set (NMDS) system, which allowed the registered manager to download a report and monitor training compliance.

New staff completed an induction to the service, which included the registered provider's values, policies and procedures, lone working, equal opportunities, professionalism and code of conduct, uniform, care records and continuous professional development. Staff told us they were not allowed to visit people until they had successfully completed their induction. All new staff were enrolled on the Care Certificate. The Care Certificate is a standardised approach to training for new staff working in health and social care.

Staff received regular supervisions and appraisals. A supervision is a one to one meeting between a member of staff and their supervisor and can include a review of performance and supervision in the workplace. Supervisions included a discussion on performance since the last supervision, 360 degree feedback, which people who used the service, management, staff and other professionals contributed to, identified training needs and updates, a review of policies and procedures and general comments. This meant staff were fully supported in their role.

People's nutritional needs and food and drink preferences were recorded in support plans. We saw one person who used the service was fed via a percutaneous endoscopic gastrostomy (PEG). PEG is a tube that is passed into a person's stomach through the abdominal wall, most commonly to provide a means of feeding when oral intake is not adequate. The person's support plan provided guidance to staff on how to perform the duties required and included guidance from a multi-disciplinary team meeting attended by staff, health

care professionals, GP and dietitian. The registered manager and staff had received training from healthcare professionals regarding the use of the PEG and the training was followed up by observations of staff in practice.

Another person who used the service had dysphagia, which is difficulty swallowing. The person had been assessed by the speech and language therapy (SALT) team, who had recommended the person should have a diet of thickened fluids. The person's support plan stated fluid intake charts were to be completed at each visit if staff administer any fluids. We saw copies of these completed records. This meant people were protected from the risks of poor nutrition.

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 to receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA. The registered provider had a MCA policy, which made staff aware of the requirements of the MCA and stated they would ensure that anything done for or on behalf of individuals who lacked capacity would be done in their best interests. The policy included a good practice in assessing mental capacity flow chart, which described the assessment process for establishing whether or not the person had the capacity to make decisions. Care records included information on whether people had capacity and whether GP, social workers and families had been involved. The records for the people we looked at stated people had capacity although one person's family member was going through the process of a lasting power of attorney with regard to the person's finances as the person wished for it to happen. The registered manager told us they were made aware of people who didn't have capacity. Mental capacity assessments were carried out by people's social workers and information was provided to the registered manager as required.

We observed that the service had sought consent from people for the care and support they were provided with. Each person had a care plan agreement form completed and signed by the person who used the service, stating they agreed with the plan, its contents and the information could be shared with staff and other agencies involved in the person's care. People had signed service level agreements in their care records, showing people agreed to the provision of domiciliary care in their home.

One of the care records we looked at stated the person had a Do Not Attempt Cardio Pulmonary Resuscitation (DNACPR) form which means if a person's heart or breathing stops as expected due to their medical condition, no attempt should be made to perform cardiopulmonary resuscitation (CPR). The registered manager told us a copy of the person's DNACPR was kept in the person's house.

People who used the service had access to healthcare services and received ongoing healthcare support. Care records contained evidence of involvement from external specialists including hospitals, GPs, district nurses, tissue viability specialists and dietitians.

Good

Is the service caring?

Our findings

People who used the service, and family members, were complimentary about the standard of care provided by Able Care and Support Services Ltd and told us the staff were very caring and went the "extra mile". They told us, "If it wasn't for them I think he wouldn't be here today. I've a lot to thank them for. I honestly can't thank them enough", "They go well over the extra mile. Nothing is too much for them", "The care they have provided overall has been wonderful", "They went above and beyond what was expected", "It's like having your own family caring for them" and "It's like having family caring for your parent". This showed that people and family members valued their relationship with staff.

The registered provider's comments and compliments file included comments made by people who used the service and their families. For example, "Able Care and Support Services have given us our mum back, nothing is too much trouble. I don't know what we would do without them", "It is good knowing [Name] is being looked after as well as she is", "You and your team have become an important part of our family" and "You do go above and beyond the call of duty". These comments were reflected in what family members told us.

The service had a person centred culture and staff were aware of the individual needs of people who used the service and how they wanted and needed to be supported. A family member told us, "They do little things for her. She won't eat big meals. One of them sussed out if they gave her a big plate with a meal in the middle it makes her think she is getting a small portion. They passed that on to the other staff. It worked." Another family member told us, "He laughs with them. They put music on and sing to him while they are working. They know what he likes". This showed that staff had identified alternative ways of promoting people's health and wellbeing.

The registered provider had a policy in place which described how to record the wishes of people who used the service. This recognised that some people who used the service had difficulty in recording their wishes in most conventional ways. For example, the policy stated it was perfectly acceptable for the person to make an X, initial or other mark in place of a signature and if made in the presence of a witness, the witness must record their name. And, if the person could only state their wishes verbally, it must also be witnessed and recorded in the same way. Details of friends and advocates were included in people's care records. Advocacy services help people to access information and services, be involved in decisions about their lives, explore choices and options and promote their rights and responsibilities.

The registered provider had a privacy and dignity policy which was in place to help staff understand and ensure that people who used the service were treated in a dignified way and had their privacy and dignity respected at all times. The policy described a list of values that management and staff were to follow to ensure the privacy and dignity of the people who used the service. For example, people should feel important to the staff who attended to them, staff should always knock before entering the person's home and staff should endeavour to cover the private areas of the body when assisting people with intimate care.

Support plans described how staff should respect people's privacy and dignity when carrying out personal

care. For example, "Close curtains to maintain privacy and dignity", "Cover with the other towel. You should only be exposing the part of the body which is being washed" and "Explain what you are going to do and ask permission".

We asked family members whether staff respected people's privacy and dignity. They told us, "Yes they do. He's not embarrassed. They are so well trained it's unbelievable. It is proper care what they give him. It's not rushed and out in 10 minutes. Sometimes they stay longer than they should do. They don't leave until they know everything is alright with him", "They ask her what she wants. They know how to handle her if she doesn't want to go into the shower. They share their experiences. It's documented in the book so other staff know. Because it's the same staff she sees, she knows and gets on with them", "I could hear staff talking to my mum. They spoke quietly, kneeled down next to her. Asked mum if she wanted a wash and eventually persuaded her" and "The care they provided for my mother was second to none".

The provider had achieved "Daisy" accreditation in 2014 by completing a portfolio of evidence, which included staff training, surveys of people supported by the service and direct observations of staff. Daisy is an accreditation scheme designed to foster an environment where Dignity in Care is at the forefront of everything that is done. We spoke with a healthcare professional involved with the Daisy accreditation scheme who told us Able Care and Support Services Ltd were one of the first care agencies to achieve Daisy accreditation. Re-accreditation takes place every two years and Able Care and Support Services were applying for the advanced Daisy accreditation in 2016 by completing the "Living well with dementia" accreditation.

The survey carried out by Dignity in Care included the following comments, "Able Care and Support are the most caring, professional people we have ever had – nothing is too much trouble", "It would be very difficult to improve on a company whose staff are kind, caring and truly professional" and "The family have peace of mind knowing Able Care are taking care of mum".

Staff received "Dignity in care" training and how staff respected people's dignity was checked as part of direct observations in the workplace. We discussed dignity with staff who told us, "Quite a lot of my clients are personal care. If you go in and do personal care, they are always covered, you respect their privacy. You ask what they want and whether there's anything else we can help with" and "We are constantly doing dignity training or discussing at team meetings. If something is done to promote dignity, it is discussed at the next team meeting". This meant that staff treated people with dignity and respect.

Care records showed that people's independence was promoted by staff and people were given the choice if they wanted to carry out aspects of their personal care and other tasks themselves. For example, one person required some assistance with their personal care but was able to dress and trim their beard independently. Staff were instructed to ask the person if they wanted assistance in washing but were to respect the person's wishes. The person was able to mobilise around the home without assistance, using a walking stick or furniture to steady themselves. Another person was able to care for their own glasses, cleaning them and putting them on and taking them off themselves. Family members told us staff supported people to be independent and people were encouraged to care for themselves where possible.

People's wishes for palliative care and end of life care and support were recorded in their support plans. These included who the person wanted informing, preferred funeral arrangements and whether the person wanted to stay at home or go into hospital should the terminal stage of life be reached. We saw that one person had clearly stated they wanted to remain at home and did not wish to go into hospital. Records showed how this subject was addressed in a sensitive manner and if the person did not wish to answer the questions, the staff member should refrain from asking further questions.

The registered manager told us they had assisted with people's funeral arrangements and would never turn away a potential client who was terminally ill. The registered manager told us that all staff were asked whether they would like to become an end of life ambassador and all staff had received accredited end of life training. Staff we spoke with told us, "We take end of life care clients instantly. We spent Christmas with one person who was on palliative care" and "I do end of life care, which is very rewarding. They get to stay in their own houses. I've passed my end of life certificate."

A family member told us, "They cared for my mum like nurses would. Towards the last six to eight weeks she was really poorly. The ladies and the gentleman were brilliant" and "After my mum died, [registered manager] washed her and put clean night clothes on and sprayed her with perfume. They really care about the people". This meant staff were trained in how to provide end of life care and provided the care with empathy and compassion.

Good

Is the service responsive?

Our findings

The service was responsive. We saw that care records were regularly reviewed and evaluated.

People's needs were assessed before they started using the service. This ensured staff knew about people's needs before they began to provide care and support.

People had one page profiles, which provided important information about the person. These included next of kin and emergency contact details, GP contact details, how to access the person's home, allergies, dietary needs, ongoing concerns, regular activities, contracted hours and when the service commenced.

People's support plans included details of their allocated time and day of calls. For example, the times of morning, afternoon and evening calls, the duration of the call and number of staff to attend.

Records described the person and their life so far. For example, childhood, places where the person had lived, employment, family and medical history. One person's all about me section described how they were prone to pressure sores and used an air flow mattress. The district nurse visited the person regularly to monitor and apply new dressings.

Additional information was provided on the person's pressure areas in the medical conditions section of the support plan. This described the condition, how it affected the person and assistance or practical advice required to enable the person to be supported. For example, "I need staff to be careful when handling or touching me anywhere that has been mentioned" and "Be aware that my district nursing notes say that if my dressing comes off my pressure sores I am to have a thin layer of sudocrem applied until the nurse come for their next visit and apply a new dressing". The personal care section of the person's support plan informed staff to be aware of pressure areas when carrying out personal care and monitor for additional pressure areas. It also described step by step instructions for staff to follow to prevent pressure damage when carrying out personal care.

Positional change and wellbeing charts and body maps were included in the care records. We saw the record for the person who required pressure area care and saw it had been completed at each visit and initialled by the care staff.

The support and duties section of the support plan described in detail the tasks staff were to carry out at each visit and included personal care, continence management, moving and positioning, eating and drinking, medication and communication.

Daily communication logs provided an update on each visit to a person who used the service and recorded the date, arrival time, departure time and any observations or comments. These included an update on the person's health, care and support carried out, medication administered during the visit and contact made with any health care professionals or family members.

Care records included a social interests section. These recorded what activities people liked to take part in, what support was required from staff and how staff could promote inclusion in activities. For example, one person enjoyed going out most weeks on a shopping trip. Another person was too ill to go out and the care records described how the person enjoyed the company of staff at their home. The person particularly enjoyed their radio and gadgets, taking things apart and putting them back together again. Another person enjoyed music and staff would sing along with the person and get them to put songs on the care staff member's telephone to listen to while staff carried out their duties. This meant people were protected from social isolation.

We saw a copy of the registered provider's comments, compliments and complaints policy, which explained it was the registered provider's policy that all comments, suggestions and complaints were dealt with quickly and effectively. The policy stated that all complaints received would be recorded and investigated by the registered manager within five working days of receiving the complaint. Information was also provided on who to contact if the complainant was not happy with the outcome of the complaint and included contact details for the local government ombudsman and CQC. The registered manager told us there had not been any formal complaints recorded at the service. People and family members we spoke with did not have any complaints but were aware of how to make a complaint. Family members told us, "Never had to make a complaint. I have no complaints about anything" and "No I've never had to make a complaint". This showed the registered provider had an effective complaints policy and procedure in place.

Good

Is the service well-led?

Our findings

At the time of our inspection visit, the home had a registered manager in place. A registered manager is a person who has registered with CQC to manage the service. We spoke with the registered manager about what they thought was good about their service and any improvements they intended to make in the next 12 months. The service had recently moved to new office accommodation and the registered provider had submitted the relevant application forms to CQC to add the new location. The service has recently been awarded a new contract from the local authority and would be increasing the number of people using the service. The registered manager told us staffing levels were being increased and staff from other service providers were moving across to join Able Care and Support Services Ltd. The registered manager told us they had recruited a nurse to assist with the complex needs of people who used the service and to provide professional support to staff.

All the registered provider's policies had been reviewed in April 2016. Each policy included a policy declaration sheet, which staff signed to say they had read and understood the policy.

The service had a positive culture that was person centred, open and inclusive. People who used the service and family members told us, "I know I can always ring [registered manager] and she'll be out, any time of day", "[Registered manager] and [operations manager] are hands on. They are always here", "I've learnt a lot from Able Care and Support. I wouldn't hesitate to recommend them" and "If I've had any concerns about anything or wanted advice, I felt very comfortable ringing [registered manager]. Nothing is too much trouble for [registered manager] or [enablement manager]. Both are very approachable".

Staff we spoke with felt supported by the registered manager and told us they were comfortable raising any concerns. They told us, "Any time I have any problems I can ring them at any time of day. They have an out of hours service", "They are very supportive" and "100% fully supported".

Staff were regularly consulted and kept up to date with information about the service. We saw records of staff meetings and management meetings. The most recent management meeting minutes were from 6 June 2016 and the agenda included discussions on continuing professional development, telephone manner, cover in the event of the registered manager being absent and the medication incident procedure. The most recent staff meeting took place in April 2016. The registered manager said one of the reasons there had not been a more recent meeting was because of the office move.

We looked at what the registered provider did to check the quality of the service, and to seek people's views about it.

Records of quality monitoring visits and telephone calls to people who used the service were in people's care records. These were carried out every one to two months and asked the person for feedback on the quality of the care and support provided by Able Care and Support Services Limited. The registered manager told us that because management and senior staff are regularly in people's homes monitoring staff, people were given the opportunity to verbally feedback regularly.

Management and senior staff carried our regular checks of staff in the workplace, including observations, spot checks and uniform spot checks. Staff observations and spot checks checked whether staff arrived on time, were wearing the correct uniform, whether staff knocked on the door before entering the person's home, greeted people in a courteous way, read the care plan, used correct personal protective equipment (PPE), asked whether the person needed assistance with any tasks, completed documentation correctly and promoted dignity throughout the visit. Additional comments and feedback were included from the assessor and the staff member. Uniform spot checks checked staff uniform and appearance, including jewellery, nails and whether hair was tied back. Family members told us, "Spot checks are done on them. [Registered manager] and senior staff have been waiting to check the staff are carrying their bag and sat and observed while the girls have been doing their work" and "[Registered manager] runs a very tight ship".

The provider had not sent out their own satisfaction survey as Dignity in Care had surveyed all of people who used the service as part of the Daisy accreditation. The registered manager told us they did not wish to send out their own survey at a similar time. The registered manager told us they had plans to send out their own survey at the end of 2016. The Dignity in Care survey asked people whether they found staff were polite, whether people felt listened to and supported by staff, whether they were treated as an individual, whether enough time was given to them and did they feel treated with dignity and respect. The results of the survey showed that people found staff very helpful and felt very supported.

This demonstrated that the registered provider gathered information about the quality of their service from a variety of sources.