First 2 Care Service 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 between 1 and 10 November 2017 and was announced. This service is a domiciliary care agency. It is registered to provide personal care to people living in their own houses and flats in the community. It provides a service to older adults, younger disabled adults, people living with dementia, and people with a physical disability or sensory impairments.

At the time of our inspection there were 10 people using the service who lived in Milton Keynes and Bedfordshire areas. Their head office is located in Bedford.

This announced comprehensive inspection was undertaken by one inspector. This is the first inspection of this service since it was registered.

A registered manager was in post at the time of the inspection. 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.

Staff knew, as a result of the training, what keeping people safe meant. This was as well as how to report concerns and the organisations they could contact should they suspect or identify any risk to people's safety.

The registered manager had policies and procedures in place to respond to any accidents and incidents such medicines administration errors. These procedures were effective in driving improvements to help prevent any recurrences. A robust recruitment process helped ensure that only staff who were deemed suitable due to their skills and suitable character were employed to work with people using the service.

Staff whose competence had been assessed to administer people's medicines did this in a safe way. Medicines were managed in line with current guidance.

Risks to people were assessed and managed safely including those identified within the person's home environment and whilst out in the community. Checks on equipment used by staff, such as that for moving and handling, were undertaken to make sure that it was safe to use.

People's needs were met by a sufficient number of competent staff who had the right skills to provide people with support when they needed it.

Staff were provided with training, support and mentoring that was appropriate to their role. This helped them to provide care that met people's needs in a person centred way.

People were effectively supported with their eating and drinking needs. They were also enabled by staff to

access health care services and support such as those from a community nurse.

People were supported to have maximum choice and control of their lives and staff supported them in the least restrictive way possible; the policies and systems in the service supported this practice.

People were well looked after and cared for by staff who considered people's equality and any diverse needs. People could be as independent as they wanted, or needed to be as well as being given privacy and treated by staff who respected their rights.

People were given a range of ways in which they could comment about the quality of their care. This included day to day contact with staff and frequent visits from staff with a management role. Any comments/concerns were acted upon swiftly and to the person's satisfaction.

People's care needs, including assistance with pastimes and interests were responded to by staff in a person centred way. This meant that staff promoted and supported people to lead a more meaningful life. People's end of life care was promoted in line with the latest guidance and as a result people, when possible, could spend their last days with the people and surroundings that mattered.

The registered manager had created an inclusive atmosphere within the service and this had fostered an open and honest staff team culture. Staff were supported in a positive and learning environment where any poor care would be reported and acted upon immediately.

Effective governance, cooperation with other organisations and leadership by the registered manager had implemented a system of effective audit and quality assurance. Various ways to continually improve the service were sought as well up to date information about care in the community being used to better people's quality of life.

Further information is in the detailed findings below.

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 kept as safe as possible by staff who had been trained on how to prevent, recognise and report any incident of harm.

Incidents and accidents including near misses were reported and actions taken were effective in helping to prevent further incidents from occurring.

A sufficient number of skilled and safely recruited staff were in place to help ensure that people could make choices without restrictions on their safety.

People's medicines were managed and administered in a safe and hygienic way by trained and competent staff.

Is the service effective?

Good

The service was Effective.

People's needs and choices were met by skilled staff who supported them to live an independent a life as possible as well as maximising people's choices.

People were supported to eat and drink enough by staff who had been trained for their role.

People were enabled to access healthcare services and professionals and this approach helped people live healthier lives.

Is the service caring?

Good

The service was Caring.

Staff knew the people they cared for well and how to provide them with care in a dignified, private and compassionate way. This helped remove any potential barriers such as those for people who communicated using non verbal means.

People were involved in their care as well as advocacy being used to speak up for people's rights.

People's preferences and needs were protected by staff who promoted what people could do independently.

Is the service responsive?

Good

The service was Responsive.

People's care planning and support helped ensure that their strengths were built upon to achieve a good quality of life.

People, no matter what their needs, were provided with care which was individualised and without discrimination.

People's concerns were acted upon before they became a complaint. Systems, policies and procedures as well as staff's transparency on responding effectively to concerns helped drive improvement.

People's end of life wishes, preferences and decisions were given sensitive attention to help ensure people's final days were spent in the place they wanted to be.

Is the service well-led?

Good

The service was Well-led.

The registered manager's visions in leading by example helped provide and deliver good quality care where people achieved the outcomes they wanted.

An effective governance system was in place, and this, along with an open staff culture helped improve the quality of service that was provided.

The registered manager involved people in the service and they developed the staff team's skills in a way which all staff benefitted from.

First 2 Care Service 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 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 site visit started on 1 November and ended on 10 November 2017. It included visiting the office location on 1 November 2017 to see the registered manager and office staff; and to review care records and policies and procedures. This was as well as shadowing care staff completing their care calls. We also looked at four people's medication administration records and records in relation to the management of the service and staff. This included records of accidents and incidents and six staff recruitment details. This was as well as looking at audit and quality assurance and governance processes. On the 6, 7 and 10 November 2017 we spoke with three people who used the service, two relatives and four care staff. And on 10 November 2017 we spoke with a member of the Excellence in Palliative Support Coordination Centre team (PEPS).

The inspection was undertaken by one inspector. We gave the service 48 hours' notice of the inspection visit because it is small and the manager is often out of the office supporting staff or providing care. We needed to be sure that they were in.

Not everyone using First 2 Care Service Ltd receives the regulated activity of personal care. CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided.

As part of our inspection planning we requested information from those organisations who commission care at the service. We looked at this and other details we hold about the service, which included information from notifications the provider sent to us. A notification is information about important events which the provider is required to send to us by law.

We did not request a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and

improvements they plan to make. We took this into account when we inspected the service and made the judgements in this report.

Good

Is the service safe?

Our findings

People we spoke with told us the reasons they felt safe included not being rushed, being made to feel relaxed and staff arriving and staying for the right amount of time. One person said, "This [provider] is so much better than the one I had before. I can now rely on [staff] being there for me when I get home." Another person told us, "I need a walking frame and [staff] make sure it is right by my side." We saw that this was the case.

The systems, processes and practices which had been implemented by the registered manager all helped contribute to people's safety. We saw that the registered manager monitored staff's performance in keeping people safe with spot checks and speaking with people and health care professionals. Staff's training; knowledge and skills in keeping people safe meant that staff were able to describe these processes to us. This was for subjects including the types, and signs of harm, the ways they kept each person safe, and the organisations they could report this to, such as the local authority. This was as well as information about people's safety being up-to-date and being held securely. One staff member said, "I would contact the safeguarding team if I needed but the [registered] manager is my first port of call. I trust them to do the right thing." Incidents reported to the safeguarding authority had been satisfactorily acted upon and actions had been taken to help prevent any potential for recurrence.

Information was provided to people in a format they could access and this helped them to understand what keeping safe meant. This included a service user guide that was given to people when new to the service as well as verbal information if people preferred this. People, or their representative, were, as a result of this information, empowered to raise any concerns they may have about their safety.

Risk management policies and procedures as well as risk assessments were in place to help staff manage these risks whilst doing this in a way which respected their independence and freedom. For example, using equipment to access the community or to get about at home and taking medicines. These risks were kept under regular review, acted upon and also updated after any incident such as a person experiencing a fall or after any event which had the potential to cause harm, such as medicines recording errors.

Where any risk to people was identified that required external health care support, this was reported to the most appropriate organisation. Other stakeholders, such as social workers and information shared with them all contributed to people's safety, care and support. One person said, "If I need my care changing [to keep them safe], I speak with the [registered] manager and they get straight on to whoever can sort this out." For example, the provision of equipment for people's safe moving and handling which was checked by staff to make sure this was, at all times, safe to use.

Any incidents which occurred such as staff forgetting to sign people's medicines records were acted upon effectively. For example, staff could receive extra training on medicines administration or be given a formal supervision. All staff we spoke with were very confident to report any concerns if they ever had to whistleblow. This was about any poor standards of care and that the registered manager would put measures in place to help prevent any recurrences. Staff meetings were then used to remind staff of their

responsibilities as well as any sanctions should the necessary improvements not be made.

The registered manager told us that people's needs were assessed and that the required number of staff with the right skills were put in place to meet these needs. One person told us, "I need two staff and there are always two who turn up and they know how to move me safely." One staff member said, "I have regular training to move people safely and I have my competence to administer medicines assessed every six months. Training is very good."

Staff were recruited in a safe way with checks on their qualifications, skills and suitability being completed such as an employment history and written references. One staff member told us, "I was interviewed to assess my suitability and then I had to bring in driving licence and having a DBS [Disclosure and Barring Service] for any criminal records, which came back clear." This was as well as having checks in place for the safety of people's home environment. This was to help ensure that the place where people were cared for was a safe place for staff to work in. People were assured that the risk of harm was effectively mitigated. We found that sufficient staff were deployed in a way which safely met people's needs.

The registered manager had policies and procedures about medicines and infection control for people receiving care in the community. These policies and staff training followed national guidelines and helped support people safely. We were told by people and found in records we viewed that the service made sure that people received their medicines (both prescribed and non-prescribed) as intended. We saw that the recording of people's medicines was accurate and that staff wore gloves and aprons and washed their hands afterwards. People were assured that they would be administered their medicines as prescribed and in a hygienic way.

We saw that each person could be as independent as possible with their own medicines but also the right support being provided if this was required. One person said, "They [staff] stand by me until I have taken them [tablets] all." Staff's training was then based upon each person, their needs and how best to support them. For example, by having trained and competent staff who knew what safe medicines administration meant as well as input from relevant healthcare professionals such as a GP. A relative told us, "I do all my [family member's] medicines as this is what they want."

Good

Is the service effective?

Our findings

We found that people's needs including those for social needs and healthcare had been assessed. Staff were then matched to people in a way which helped ensure that all of people's needs were looked at holistically and not just individually. One person said, "[Staff] are absolutely brilliant and I can't fault their knowledge, skills or the way they help me. I couldn't live at home without their support." Another person told us, "It is only by having this equipment [walking frame and adapted bed] that I can live at home." We saw that this promoted peoples independence.

Staff told us and we found that they had a thorough induction and on-going opportunities for development. This enabled them to have the skills and confidence to carry out their role. Staff completed the Care Certificate (a nationally recognised qualification in care) when new to the service and staff were able to progress with management qualifications and experience. One staff member told us that they had, "a very good induction with shadowing experienced staff" until they were confident to work on their own. Another staff member said, "I have worked in care before but learning about care at home has been really interesting. I have also got experience of people who live with dementia. I am happy that the training I get makes it possible for me to meet each person's needs."

Records we viewed showed that a programme was in place so that staff got the training, supervision and mentoring they needed. This was so that they knew what was expected of them and the level of care each person needed. One person told us, "I think that they [staff] know me well, they have good communication skills and how best to make sure all my needs are provided for." We saw and people told us that their meals were not rushed and staff knew what foods people could or couldn't eat. A staff member said, "My training includes food hygiene, the MCA (Mental Capacity Act 2005), moving and handling, safeguarding, infection prevention and control as well as dementia care. This training enabled me to put myself in the person's position. We have developed a communication passport which helps ensure that [people's] wishes are communicated and understood by us."

We observed staff preparing people's lunch and refreshments they had chosen and that this was done hygienically. People were given a range of options and could change their mind if they chose to. One person said, "My [family member] does my meals but staff sometime stand in if they are out. I am happy either way." A relative told us, "I have no problem with my [family member's] nutrition. I get them the foods they prefer. Sometimes they [staff] help me prepare meals. It depends if I have time."

We found that staff's development was a central part of meeting people's assessed needs. Staff's training was up to date and refreshers for various subjects such as first aid, fire safety, equality and diversity and the Deprivation of Liberty Safeguards (DoLS) had been completed. Staff put the skills they had been empowered with into good effect. They also ensured people's human and legal rights were respected. One person told us, "They [staff] have definitely got the skills to care for my [health condition]. They don't rush me and I feel very calm with them in my house."

The registered manager kept up to date with any new guidance or changes in best practise regarding care in

the community such as medicines management and end of life care. Staff's learning style was then adapted to get the best out of them such as classroom training, hands on learning or mentoring by management staff. This was as well as liaising with community nurses for people who had shared support needs.

The registered manager told us that they had a good working relationship with community health care professionals and that any change in a person's health was acted upon quickly such as the provision of pain relief. As a result of these interventions people led the life they wanted. We saw that staff consistently applied any health care guidance such as that for catheter care. People's care plans recorded the way people needed to be cared for with regard to their health conditions. Examples included regular repositioning as well as drinking sufficient quantities. A relative told us, "They [staff] have been amazing. Not just for my [family member] but also for me. It hasn't been easy but I know my [family member] has the right healthcare."

The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. People can only be deprived of their liberty so that they can receive care and treatment when this is in their best interests and legally authorised under the MCA. We checked whether the service was working within the principles of the MCA, and whether any conditions on authorisations to deprive a person of their liberty were being met.

People's mental capacity to make decisions was determined by the registered manager and respected. Staff were able to describe to us how people were supported to make a decision and that their choices were respected even if this appeared to be an unwise choice. The registered manager told us about the systems that were in place to deprive people of their liberty with restrictions to keep people safe if this was ever needed. For example, by contacting a social worker who would refer the matter to the Court of Protection and they would put safeguards in place to protect people who lacked mental capacity. Examples of this could include staff supervising people when they were out in the community.

Good

Is the service caring?

Our findings

Everybody we spoke with described their, or their relatives, care as being compassionate, friendly and caring. One person said, "I am absolutely happy with my care. [Staff] are just so in touch with me. This makes me feel so calm and relaxed. They protect my dignity and give me privacy when I need it." A relative told us that the difference the staff made to their family member's life was huge. They said that this was because staff were "simply the most compassionate people I have ever come across. I couldn't manage without them."

We saw how staff listened to what people said or communicated to them and then acted in a sensitive way on the person's wishes. We saw how staff spoke with people clearly and respectfully. This was as well as being able to communicate well with any person who had a sensory impairment. Another person told us, "I appreciate everything they [staff] do for me. Just so nice and friendly." People could be confident that staff would treat them with respect.

We found that two out of the four people's care plans we looked at contained only limited information about people's care needs. For example, "move [person] into their comfy chair" without any detail of how this was to be undertaken. In addition, the associated risk assessment advised staff to move the person "using the techniques you were taught in training." Again, there was no detail about how staff should complete this task. Staff were however, able to describe to us in detail how these task were undertaken, the equipment to be used as well as how to do this in a way which supported people's dignity in a caring way. The care coordinator told us that they would add further details about these tasks to people's care plans.

Other aspects of people's care included details about their preferences, any religious following, life histories, likes, dislikes and how they preferred to be cared for. Examples of this included, cereal with cold milk, lunch at 1pm and the size of continence pads at night time and during the day according to the person's needs. We found from the staff we spoke with that they knew how best to meet people's needs in a person centred way.

We observed how people who needed to be spoken with face to face to ensure they understood staff's communications did this in a kind way. Staff were patient in waiting for people to answer, listened to what they said, and then took the necessary actions. A relative told us, "They are the most patient people you could ask to meet. They give me time to have a breather. I am in awe at how caring they are to my [family member]." A staff member said, "I treat each person as if they were one of my family members. I can't imagine not providing the best care we can especially at some very important and sensitive time of people's lives." We also saw how, prior to completing a care call, staff asked people if they wanted anything else doing. People could be confident that staff would see and treat them as an individual, make a difference to their lives and do this as compassionately as possible.

People or their advocate such as a family member contributed to the person's needs. One person told us, "[Name of staff] came to see me before they [provider] started caring for me. It was a thorough process. I am confident that as a result of this, my care plan reflects my needs and me as the person I am. I know that

when I have personal care that this will be as private and caring as it can be."

Staff described how people's dignity would be maintained such as closing the door and blinds and covering people with a towel. This was as well as explaining the care that was going to be provided and giving people time to have their privacy. When shadowing staff we found they maintained people's privacy during the care call. This showed us that people were put first.

People we spoke with told us that the care staff maintained their confidentiality and only discussed information relevant to the person being cared for. One said, "I only ever hear staff talking with me about my care. They might discuss any changes in my care with me but never anyone else's. I would expect the same about my care."

Good

Is the service responsive?

Our findings

People told us that the agency provided a service that was flexible and responsive around their needs. For example, we saw they did this by regularly reviewing care plans and making changes promptly. One person said, "The [Registered] manager or other office staff comes to see me every few months I think. If I have anything urgent I just call them and action gets taken." Another person told us, "There is always somebody in the office. If I leave a message, they get back to me quickly. For example, if I need to cancel a care call or add an extra one it's never an issue. They are brilliant and make such a difference to my life to remain in my own home." A relative told us, "My [family member] has some very complex needs which they [staff] completely understand. They have made such a difference to their life and mine too. I'd be lost without them. It is sometimes the very small things such as enabling me to have a rest that makes such a difference. It helps me to be recharge my batteries which is important to my [family member]."

We found that people were treated equally no matter what their level of independence or care needs. One person told us, "I can't praise them [staff] enough for what they have done and do for me on a day to day basis. If I need an extra call they just sort this out. If I am going to be late home there is always one of them to meet me." As a result of the registered manager's and staff's interventions people had benefitted and were able to lead meaningful lives doing the things that were important to them. People's care plans were up-to-date and included details of their interests, pastimes and hobbies, such as going outdoor bowling, swimming, going to a café, reading a book or newspaper or doing some train spotting. One person told us, "I go out lots now and this has been down to them [agency]."

We found that staff had worked hard to identify social stimulation in advance of meeting the person's needs. This forward planning included the type of films they liked to watch, which events they like to attend as well as their favourite eating places. A relative told us, "They [staff] may be the only people we see regularly but what a difference they make to [family member]. We have a chat and they do listen to us. I know because they continue the conversation next time they come." People's care plans were up-to-date and daily care notes recorded the social stimulation that had been provided. This had been according to the person's preference, such as watching TV, going out or listening to their favourite music. A member of the PEPS team said, "They [registered manager] put people in touch with us and this helps people and their family members with emotional support. We have had no concerns at all."

We found that people were encouraged to maintain contact with friends and others who were important to them. Examples we saw included people now going out into the community where previously they would not. This had been due to staff making this possible and removing the barriers that the person saw which had prevented them from doing so in the past. This had also been achieved with involvement of other stakeholders and with the person's agreement, People lived a better life as a result of the care they received that was adaptable to their changing needs.

People we spoke with had not had a need to make a formal complaint. People were comfortable in explaining to us that if they had any minor issues or concerns that swift and effective action had been taken. One person told us, "I didn't like one girl [staff] and she was replaced. It wasn't their care, Just that I couldn't

get on with them." Another person said, "I requested an earlier care call that was longer and I now get this which is better for me." Records showed that people's concerns had been responded to sensitively and with the person's wishes at the heart of the matter. People could be assured that their concerns would be dealt with to their satisfaction. A relative told us, "The [registered] manager and I have talked about minor problems in the early days. We have resolved them now.

We saw that the registered manager was following the latest end of life care Recommended Summary Plan for Emergency Care and Treatment guidance. By following this process a summary of personalised recommendations for a person's end of life care had been created. It also included any, or potential need for clinical care in a future emergency in which a person may lose the capacity to make or express their choices.

We found from records viewed and people, or their relatives, we spoke with that a shared understanding of the person's current state of health and how it may change in the foreseeable future had been determined. For example, choices about spending their final hours in a place they loved such as in their own home and with those people they wanted with them. The registered manager told us about community nursing that had been put in place as well as any future pain relief to help ensure people's end of life care was as dignified as possible. We also found that any decision for resuscitation had been considered and if this was in the person's best interests.

Good

Is the service well-led?

Our findings

The care coordinator told us that, "The [registered] manager has mentored me into the person I am today. We often discuss the values we need to demonstrate to staff and how this impacted upon the people we care for." Staff told us that they had regular support and formal supervisions where they discussed what was working well and if any changes needed to be made. This was for subjects, such as increases in staff numbers, changes to care call rounds as well as any training that was due.

The registered manager told us that they motivated staff through on the job training, a combination of staff, and one to one, meetings. This was where they shared any matters with staff that needed to be improved upon. The registered manager told us that one item they were considering introducing was a monthly award for staff to help drive improvement improvements and consistency. Discussions with staff included recording people's administered medicines on the correct form and not in daily care notes. We saw that there had been improvements made on this matter.

The registered manager led by example and had fostered an open staff culture where their honesty was valued in reporting incidents. This had been achieved by working with care staff on care calls, observing their quality of care practise and developing staff to be the best they could be.

Staff told us that as a result of their training on whistleblowing that they were completely confident and comfortable in raising any concerns if required (Whistleblowing is where a staff member could raise concerns, usually to their employer or the Care Quality Commission, about a situation where people's standard of care may have fallen below that which was expected. One staff member told us, "I am absolutely certain that [registered manager] would support me. I am confident, due to the way I have been supported during induction and training that they would listen to any concerns." All staff we spoke with described the service that was provided as "a team effort ". And that if any concerns about people's care were identified, the openness of the culture would ensure that this would be reported and acted on and if required disciplinary action could be taken.

All of the people, relatives and staff we spoke with spoke highly of the agency and about the quality of service it provided. For example, people referred to the registered manager by name and how they were very approachable. One person said, "There has never been a time when I have not felt comfortable in raising any minor concerns. I think the [staff] team is brilliant and amazing. I couldn't do what they do. They do whatever I ask and they are very flexible." A relative told us, "The [registered] manager had vision to keep improving the service and I can't fault this or the quality of [family member's] care."

Compliments such as those from the local authority and healthcare professionals were used to help identify what had worked really well for people's care. One example from a social worker recorded, "I am impressed with the management, that they lead by example and that they have completed many visits to not only support their staff but to ensure that they had a full understanding of [person's] needs. I can only commend them for their support."

A registered manager was in post and had been so since September 2015 when the service was first registered. The service started to provide a service in June 2016. 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.

The registered manager understood their responsibilities in reporting untoward events such as allegations of harm. However, although the appropriate safeguarding procedures had been followed, we found that reporting these incidents to the CQC had not been completed without delay. The registered manager told us that they had waited until the safeguarding team had investigated and that the allegation had not been substantiated. The registered manager told us they would notify us straight away and that this was an oversight and not intentional. We had however, been sent other notifications as required.

A relative told us that senior staff always made sure that the right protective clothing was worn by staff. We saw and found that the values of the agency had considered people's sensitive, as well as cultural needs were demonstrated by staff. Staff knew what was expected of them in providing high quality care that met people's expectations.

Where incidents had occurred, such as an error in recording an administered medicine or a missed call due to traffic, actions had been taken. For example, by monitoring staff more frequently, providing extra training or covering a care call with office staff if no other staff were available. The registered manager explained to us how their quality assurance and audit processes had been effective in identifying a frayed item of lifting equipment, that it had been quarantined and replaced straight away. This was achieved by working with other stakeholders involved in people's care such as commissioners of their care.

People and staff were involved in contributing how the service was run and how the provision of care was determined. For example, we saw that the registered manager and other staff met regularly with people. This included when care was provided as well as discussing at this time how best to maintain links with the community for people who wanted this. We saw several examples where staff had transformed people's lives by this approach. One such example included a person who prior to using the service never went out, to a person who now attended many events such as, those involving music. The way in which each person, staff member or relative contributed to driving forward improvements was in a manner they preferred. This could be the phone, by e-mail or face to face. This helped make sure that all people's opinions were sought and respected. Changes made included working with the local authority, commissioners of care as well as making referrals for equipment or healthcare support to enable people to continue living at home.