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Burton Home Care

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

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

Summary of findings

Overall summary

The inspection took place on 22 and 25 May 2018 and 15 June 2018 and was announced. This was the first inspection of the service since it was registered in March 2017.

Burton Home Care is a domiciliary care agency. It provides personal care to older adults and younger adults living with a disability people living in their own houses and flats in the community. At the time of the inspection the service was providing 350 hours of support to 32 people.

Burton Home Care was managed by a person who was registered with the Care Quality Commission as the provider and registered manager for the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service. 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 service was not always safe because risk assessments, did not consistently provide the information and guidance staff needed to understand and minimise risks, particularly when people were at risk of choking. This concern was discussed with the registered manager and field care supervisor. They responded by reviewing all risk assessments and care plans, and amending them where necessary to ensure their accuracy and help keep people safe.

There was a risk that people's rights were not protected because they had been assumed to have the capacity to make decisions about their care. However, their capacity assessment, information in their care records or feedback by family members suggested this may not be the case. In addition consent forms had not always been signed, where people had been asked to consent to the support being provided and information being shared. We discussed this with the registered manager and field care supervisor who responded by reviewing all of the capacity assessments and consent forms to ensure they were correct and people's rights were protected.

There were systems in place to regularly monitor the service and make improvements where necessary. This included regular audits of care records, which had not identified some of the issues we found. We discussed this with the registered manager and field care supervisor who then carried out an audit of all care records and were considering how their quality monitoring processes could be more effective. Although, there was a positive and immediate response to the concerns raised and action was taken, more time is needed to allow the changes to become embedded into practice.

Other quality monitoring processes included feedback from the people using the service and the staff supporting them, and unannounced spot checks of staff practice. In addition an electronic monitoring system allowed office staff to monitor visit times and duration and ensure people were supported in line with their care plans. The management team themselves provided hands on care, and knew the people using the service well. This provided additional opportunities to ask people about the quality of the support

they were receiving.

People told us the service was well run, and praised the management team and all the staff. The management team had learnt from their experience as care workers for larger companies, and, although the registered manager was increasing the level of service provision, they planned to keep the service small so that the quality of support could be maintained. One person said, "If there was an award for care companies there is only one care company that would be up there." The registered manager had an open and transparent management style, and welcomed the feedback given during the inspection. They were committed to learning from any mistakes and acted immediately to address the concerns raised.

Staff told us they felt well supported. They received regular supervision and attended quarterly staff meetings where they were able to express their views about the development of the service. They completed a comprehensive induction and mandatory training on a range of topics which was refreshed every 12 months. This was delivered face to face by the registered manager, who was a qualified and experienced trainer. Bespoke training was arranged if required to enable staff to understand and meet people's specific needs.

People told us they felt safe. They said they received a consistent and reliable service. Burton Home Care had a system for identifying the most vulnerable people, which meant their needs would be prioritised if there were any problems affecting service provision. They did not accept referrals unless they had the capacity, skills and experience to support the person effectively. Rounds had been carefully planned to ensure people had a consistent team of care staff with enough time to meet their needs and the flexibility to respond to any additional requests for support. People were confident they could raise any complaints or concerns with the provider and these would be dealt with promptly and satisfactorily.

People were protected from abuse and harm because staff had completed training in safeguarding adults, and knew how to recognise and report safeguarding concerns. Burton Homecare had worked closely with the local authority and other agencies to report and investigate safeguarding concerns and take any action necessary to keep people safe.

Before people began receiving a service an assessment was carried out to assess any risks to the person using the service and to the staff supporting them. A care plan was drawn up with each person and reviewed with them regularly. The care plans explained how to support and encourage people to remain independent. They contained easy to read and clear information about the support the person needed and how they wanted it to be provided, including any support they might need with communication. This enabled staff to provide safe and effective care.

People's health needs were monitored and prompt action was taken to support people to seek advice and treatment from health and social care professionals where necessary. Where people needed assistance with medicines, staff had received training and knew how to support people safely.

The service was caring. People were supported by staff who knew them well and understood their needs. We heard many examples of praise for care and kindness of the staff. Comments from people included," They are absolutely brilliant, I am more relaxed than I have been for years. They have made such a difference to my life, let alone my husbands. The carers know us and we know them. "

The registered manager was committed to promoting equality, diversity and human rights at Burton Home Care, ensuring staff shared their values and increasing staff awareness through training. Care records reflected the diverse needs of people using the service including those related to disability and faith. These

needs were recorded in care plans and staff we spoke to had a good understanding of them.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not always safe.

Risk assessments were not consistently accurate and did not always contain the information staff needed to minimise the risks.

There were sufficient numbers of suitable staff to help keep people safe and meet their individual needs.

People received their medicines when they needed them and these were managed and administered by staff who were competent to do so.

People were protected from abuse and avoidable harm.

Is the service effective?

Requires Improvement

The service was not always effective.

People's legal and human rights were not fully protected.

Staff were well supported and received regular training and supervision.

People received the support they needed to maintain their nutrition and hydration, and ensure their health needs were met.

Is the service caring?

Good

The service was caring.

Staff were kind, patient and professional and treated people with dignity and respect.

Staff were committed to promoting people's independence and supporting them to make choices.

Equality and diversity was respected and people's individuality supported.

Is the service responsive?

Good

The service was responsive.

People received care and support in accordance with their needs and preferences.

Care plans were reviewed with people to ensure they reflected their current needs.

The service had an effective and thorough process for managing complaints which people told us they would feel confident to use.

Is the service well-led?

Requires Improvement

The service was not always well led.

Quality assurance processes were not always effective in monitoring the quality and safety of the service.

People were supported by a motivated and dedicated team of management and staff.

The provider/registered manager was clear about their values and vision for the service, and worked to ensure these were understood and implemented by the staff team.

The provider/registered manager had developed a culture of transparency and honesty. They were committed to continuously learning and improving for the benefit of the people using the service.

Burton Home Care

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.

This inspection took place on 22, 25 May 2018 and 15 June 2018 and was announced. We gave the service short notice because we wanted to meet the provider/registered manager and needed to be certain they would be available during the inspection. This also gave them time to ask some people if they would be willing for us to contact them by telephone to ask for their views of the service. The inspection was carried out by one inspector and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

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

During the inspection we went to the provider's office and spoke to the provider, field care supervisor and other office staff. We looked at a range of records the provider is required to maintain. This included six service user support plans, medicine administration records, staff rotas, six staff recruitment files, staff training records and quality monitoring records. We also looked at records of accidents, incidents, compliments and complaints and safeguarding referrals. We spoke with four members of care staff. We visited two people with their permission in their own homes and undertook phone calls to eight people, including family members that used the service. We had feedback from one health and social care professional.

Requires Improvement

Is the service safe?

Our findings

The service was not always safe because risk assessments, did not consistently provide the information and guidance staff needed to understand and minimise risks. The risk assessments covered a wide range of potential risks including risks related to mobility, medicines administration, the environment, security and fire. However they did not always reflect the risks identified in the initial referral information, which meant staff were not informed about these risks or the action required to keep the people safe. For example, two people referred to the service had been described as being at significant risk of choking due to swallowing difficulties. The risk assessments subsequently completed by the service did not identify choking as a risk for either person. Staff we spoke to confirmed they were unsure whether these people were at risk of choking.

We fed back our concerns about the assessment of risk to the manager and staff, and by the second day of the inspection action had been taken. Risk assessments and care plans had been amended to reflect the risk and action needed to reduce it. A message had been sent to all staff to advise them of the amended care plans. An audit of all risk assessments and care plans was in progress to ensure their accuracy. However, although there was a positive and immediate response to the concerns raised and action was taken, more time was needed to allow the changes to become embedded.

People told us they felt safe using the service. Comments included," They are absolutely brilliant, I am more relaxed than I have been for years. They have made such a difference to my life, let alone my husbands. The carers know us and we know them "and, "It's such a relief to have them. We are very lucky as a family. It gives me peace of mind and enables me to work."

Burton Home Care provided a reliable service. The staff rounds had been constructed carefully to ensure consistency and allow care staff plenty of time to spend with people. People told us they did not have missed visits and staff stayed for the expected length of time. One person commented, "I have regular staff, a fresh rota every Saturday. If they are running late the office will ring."

There were systems in place to ensure people would not be placed at risk if there were any problems affecting service provision, such as staff sickness or adverse weather conditions. People's level of vulnerability was assessed to ensure the most vulnerable people would be prioritised if there were any problems, for example if their visits were 'time critical' because they needed their medicines, food or fluids at specific times. A new monitoring system was being installed which required care staff to log in and out of every visit on their mobile phone, and alerted the office if the member of staff was more than 15 minutes late. All of the office staff, including the registered manager, were trained carers who provided additional cover when required. An 'on call system', ensured there was management support available 24/7. Staff told us, "They are always at the end of the phone, and they give sound advice. They are so supportive. You can phone them at any point if you've got any concerns."

Where staff assisted people with medicines this was managed well. Medicines were clearly documented in care plans and medicine administration records (MAR charts) completed by staff. People signed a form

consenting to staff supporting them with their medicines, and any religious or cultural issues which may impact on them taking medication were identified. All staff had completed training, and regular spot checks were completed by senior staff to monitor any issues such as gaps in recording. The management team had an open and transparent relationship with care staff, encouraging them to report any medication errors to the office, or report any errors that had been made by a previous member of staff. They had been advised, "If you notice an error that a carer has done before you, by telling us you are supporting them and the client and the business to provide a safe and caring service."

The service protected people from the risk of abuse through the provision of policies, procedures and staff training. Staff knew about the different forms of abuse, how to recognise the signs of abuse and how to report any concerns. They were confident that the registered manager would act immediately to address any concerns raised. During the inspection we saw safeguarding concerns were being managed appropriately, with Burton Home Care working with other agencies to ensure the concerns were fully investigated and action taken to keep people safe.

The risk of abuse to people was reduced because there were effective recruitment and selection processes for new staff. Before commencing work all new staff were thoroughly checked to make sure they were suitable to work with vulnerable people. These checks included seeking references from previous employers and carrying out disclosure and barring service (DBS) checks. The DBS checks people's criminal record history and their suitability to work with vulnerable people. Staff disciplinary procedures were in in place, and had been used effectively.

There were clear processes in place for managing accidents and incidents. First Aid training was mandatory and delivered on site by the registered manager. Staff took care of any immediate medical needs and informed the office about what had happened. The office continued to monitor the situation and ensure that all necessary action had been taken to ensure the person's safety.

People were protected by safe infection control practices. All staff received training in infection control. We observed them using hand steriliser, gloves and aprons during their visits, which they carried with them. Regular observations and spot checks by senior staff ensured this was maintained.

Requires Improvement

Is the service effective?

Our findings

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 MCA requires that as far as possible people make their own decisions and are helped to do so when needed. When people lack mental capacity to take particular decisions, any made on their behalf must be in their best interest and as least restrictive as possible. We checked whether the service was working within the principles of the MCA and found some improvement was required, to ensure the protection of people's rights, where they lacked the mental capacity to consent to aspects of their care or treatment.

Care plans contained an assessment of people's capacity to make decisions about their support, including personal care, nutrition, medicines, money, continence and assistance with meals. However some people had been assessed as having capacity to make these decisions when their capacity assessment, information in their care records or feedback by family members suggested this may not be the case. For example, one person with assumed capacity was documented as having severe memory loss. Their capacity assessment recorded that they were unable to retain information long enough to make a decision. Their family member was concerned staff did not appreciate the significant impact of the persons memory loss when they were supporting them. This assumption of capacity meant that there was no reference in their care records to ensure any decisions made, were in the person's best interest, and ensuring their rights were protected. In addition consent forms relating to people's support and the sharing of personal information with, support workers, GP, family, and regulatory bodies, had not been signed. This meant it was unclear whether people had given their consent.

We fed back our concerns about the protection of people's rights to the registered manager and field care supervisor. They provided reassurance that they would take immediate action to review capacity assessments and consent forms to ensure they were correct and people's rights were protected. Although there was a positive and immediate response to the concerns raised and immediate action had been taken, more time was needed to allow the changes to become embedded.

Overall people spoke positively about the knowledge and skills of the staff supporting them, although a family member and health and social care professional expressed concern about their understanding of people with very complex needs. Written feedback stated, "I can't fault the care at all. They are all very caring and know their jobs. They always have a smile on their faces." Other people commented, "The care is very effective. I couldn't manage without it" and, "They are very good, [carers' name] is brilliant, very good indeed. I can't fault them."

The registered manager was a qualified and experienced trainer, and delivered face to face training in a well-equipped training room at the office. They had developed a comprehensive induction programme which consisted of three days of training and at least two days shadowing more experienced staff. New staff also undertook the national care certificate, a more detailed national training programme and qualification for newly recruited staff. Before being 'signed off' to work unsupervised, an observation of staff practice and competency in medicine administration was carried out by the registered manager. This was repeated after

they had been in the role for two weeks and at regular intervals thereafter. This ensured staff were able to meet people's needs effectively and safely. Staff commented, "The induction was fantastic, and really detailed. We covered law, health and safety, fire safety and medicines. It's so important not to get the medicines wrong" and "It was a brilliant induction. The training was great. [Managers name] explains clearly and make sure we understand."

Staff kept their skills and knowledge up to date thorough mandatory training which was refreshed every 12 months. This included safeguarding, moving and handling, medication and infection prevention and control. Training in equality, diversity and inclusion looked at race, culture, beliefs, sexuality and gender reassignment. Staff were asked to consider, "How can you be culturally sensitive to people's needs?" and, "What can we do to promote equality and inclusion?" Specialist training was arranged with external trainers if required, and a trainer in dementia had been booked to deliver practical experiential training twice a year.

Staff told us they were well supported. Spot checks were completed every three months and followed up in a formal supervision meeting. This provided an opportunity for staff to identify what they were doing well and areas for improvement. A new member of staff told us, "I've already had a spot check. If you are doing something wrong it's good to have it pointed out, and discussed in supervision." Training was arranged to meet the identified learning needs of staff and their continual professional development was supported. Another member of staff commented, "I've just had my first supervision. I want to do an NVQ (national vocational qualification) and end of life training."

Where required people were supported, as part of their care package, to access food and drink and maintain their nutrition and hydration. We observed staff supporting people according to their preferences, and the information in care plans supported them to do this. For example, "Please ask what I would like to eat for my tea. All my choices will be in the fridge" and, "Ask if I would like a hot drink and what drink I would like left in my bedroom."

Records showed that staff supported people to access appointments if needed and liaised with health and social care professionals involved in their care if their health or support needs changed. The registered manager told us, "We don't do healthcare, we deliver care. As soon as any health care needs are recognised we will refer to the district nurses."

Good

Is the service caring?

Our findings

We saw staff had a positive relationship with people they were supporting. People told us the staff were kind and caring, including the registered manager and office staff. Comments included, "I get the feeling that their hearts are in the right place. They try their best to do their very best" and, "I think they're brilliant. They are so friendly. They will do anything they can for you. I had a fall the other day, several have phoned up to check I'm ok."

People were supported to express their views, and make decisions about their care and how it was provided. They confirmed they had been involved in developing their care and support plan, identifying what support they required from the service and how this was to be carried out. If they contacted the office to request any changes, the changes were made straight away. One person told us, "They make any changes to the care plan that they need to. They listen to what you want. They are flexible and have a good understanding." The registered manager said that as a small provider, they were able to advocate for people and respond quickly to requests for support. They said, "I can promote independence. I can make an immediate decision. A client may phone us up. You will see us openly discuss their situation, we will fight for them. We will talk to the local authority, to their family. We are able to as there is no red tape."

We observed that staff asked people for their consent before supporting them and treated them with dignity and respect. On leaving they asked, "Is there anything else I can get you?" One person commented, "They are really respectful and the house is spotless with things put back and the bed made. I am very impressed." Another person said, "They will ask me if I want a wash and cream me all over. I don't let [male carer's name] do my personal care. I prefer female carers to help." A member of staff told us that they respected people's privacy while they were washing themselves, asking them, "Do you want me to go away while you do it?" They said, "It's good to be chatty and make conversation, as it helps people feel more comfortable and relaxed." I think, "If it was me, how would I feel?"

Staff were committed to promoting people's independence and supporting them to make choices. A member of staff said, "I always give them a choice. With clothing, it might be about colours or whether they are going anywhere nice. I might make a suggestion. It's always best to put too many layers on so they can 'unwrap' if they get too hot." Another member of staff told us they involved people in decisions about their care as much as possible, saying "I don't make any assumptions. Although it's in the care plan, there might be some days when the person doesn't want a shave. I will give them the option."

Staff gave us examples of how they had provided support to meet the diverse needs of people using the service including those related to disability and faith. These needs were recorded in care plans and staff we spoke to had a good understanding of them. They told us about the training they had done and said, "Nobody should be treated differently due to their race or because they are LGBT (Lesbian, Gay, Bisexual, Transgendered). We don't discriminate. We would support people as they request to be supported." The service improvement plan for Burton Homecare showed that the registered manager was working to identify external agencies who could offer additional support to staff and people using the service related to equality, diversity and inclusion.

Good

Is the service responsive?

Our findings

People received personalised care that was responsive to their needs. The majority of referrals came via the local authority brokerage service, but the registered manager would not accept them unless they were sure the service could support the person safely and effectively. They told us, "I'm about trying to provide the service people need. We are still in the early stages of growing. We don't provide complex care, although we might do in the future. Before taking on clients we ask, "Can we do it safely? Do we have the staff available? Do staff have the training they need to support the person?" If we can't do it we won't take it."

The registered manager and field care supervisor consulted with each person and/or their families and representatives to draw up and agree a plan of their support needs. There was also input from health and social care professionals if required. People confirmed they had been involved in setting out how they wanted staff to support them in all aspects of their care. They told us, "[Manager's name and field care supervisor's name] came out and did the care plan when I first joined. They listened to what I said and put it in the care plan."

Care plans were stored electronically on the computerised care planning system, with a hard copy kept in a folder in the person's home, and a duplicate in the office for staff to refer to. They contained information about people's support needs and any related risks, including medication, moving and handling, eating and drinking, personal care needs, daily routines and social activities. MAR charts (Medicine Administration Records) and daily records were also in people's folders for completion by staff. Care plans also contained the information and guidance staff needed to help them understand the person and their needs, and how they wanted their care to be provided. For example, one person's care plan stated, "I am a very strong believer of my faith and would like you to respect this when with me." Staff understood this and supported the person in line with their care plan. Another person's care plan documented their preferences about medical treatment in line with their cultural beliefs.

Staff told us the information in the care plans was clear and easy to follow, and this enabled them to support people effectively. Comments included, "The care plans are brilliantly laid out. There's a bit about the person and their background, which helps with the conversation. You know exactly what you've got to do" and, "The plan is in plain English. It's clear. It tells you exactly what is needed for the client. How they like their cup of tea. Their ailments, medicines, equipment used…everything you need to know."

The field care supervisor reviewed people's packages of care with them at least every three months, or more frequently if their needs changed. They checked care plans, risk assessments and medicines information to ensure their accuracy, as well as the daily records completed by staff. People were fully involved in this process, telling us, "[Field care supervisor's name] checks the care plan right through and asks if everything is ok. They will ask every so often if there's anything else I need. It gets put in the care plan". The registered manager had oversight of the review process and told us they were continually looking at ways to improve people's situations even if they were happy with the service. They gave an example of how they had linked one person with 'Men in Sheds", a local project supporting older men to get together, share and learn new skills.

The Accessible Information Standard is a framework put in place making it a legal requirement for all providers to ensure people with a disability or sensory loss can access and understand information they are given. The service was proactive in identifying any communication needs and care plans provided the guidance staff needed to facilitate effective communication. For example one persons care plan stated, "I am able to lip read if people look at me and speak clearly." Staff told us they stood close to the person when talking to them, saying, ". I'll wait until they face me before talking to them so they can lip read." The registered manager had not been aware of the Accessible Information Standard prior to this inspection, but acted immediately to research it in order to develop a clear policy and process and ensure this legal requirement was met.

People told us they knew how to make a complaint and the majority of people we spoke to were confident they would be listened to and action taken. Comments included, "I understand and know how to make a complaint or compliment if I needed to" and, "If there's anything wrong you can phone them. I would be happy to ring if I was unhappy or had a complaint about anything." In the PIR the registered manager said, "We will respond to any concerns raised by the service user or by the care staff in relation to any concerns or compliments that may be reported to the office. These will be investigated and recorded in line with our complaints and compliments procedure. We aim to respond immediately to any concerns using every concern or complaint as an opportunity to improve our service."

Requires Improvement

Is the service well-led?

Our findings

The provider had systems in place to check the quality of the service. Regular audits were carried out, looking at areas such as the completion of Medicine Administration Records (MARs), daily records and care plans. However, these processes had not identified some of the issues we found during our inspection, or ensured action was taken to address them, for example the inaccuracy of some risk assessments, mental capacity assessments, and unsigned consent forms. We discussed this with the registered manager and field care supervisor who responded immediately by reviewing all of the documentation to ensure its accuracy and amending it where necessary. They also took action to review their audit processes to ensure they were effective. Although, this was a positive and immediate response to the concerns raised, more time was needed to allow the changes to become embedded into practice.

The quality of the service provision was monitored by seeking people's views through the review process and the completion of regular unannounced 'spot checks' This included arriving unannounced during a visit to observe the standard of care provided, and reviewing the care records kept at the person's home to ensure they were appropriately completed. Records showed that the findings of the spot checks were discussed in staff supervision and any concerns followed up, with additional training arranged if required.

Care staff were encouraged to be open and transparent and report any concerns to the office, for example if there had been an error in medicines administration or a late visit. They had been advised, "If you make an error the first thing to do is ring the office…We have an open and transparent relationship…If you notice an error that a carer has done before you, by telling us you are supporting them and the client and the business to provide a safe and caring service." Staff told us this approach meant that they were happy to report concerns. An electronic call monitoring system was being installed which would allow office staff to monitor visit times and duration to ensure people were supported in line with their care plans.

People told us it was a well led service and they would recommend them. Comments included, [Manager's name] is top notch. I couldn't fault the service at all" and, "If there was an award for care companies there is only one care company that would be up there."

The service was managed by a person who was registered with the Care Quality Commission as both provider and registered manager for the service. They were part of a management team which included a field care supervisor, office manager and operations manager. All provided hands on care to people as required. The registered manager said, "I chat to clients all the time. They can be so socially isolated. I know every one of our clients personally. I do care as well as the rest of the office team. Clients are part of our extended family. They aren't lost in the system."

The registered manager told us the management team had previously worked as care workers for larger companies where people had not received personalised care and staff had not been well supported. There had been "too many clients, not enough care staff and inadequate training." They had learnt from this experience and were now developing a service which "provided the best possible care", where the focus was on the 'clients' rather than making money. In practice this meant "having time to develop the service slowly.

Not taking on too many clients. Building the rounds properly and making sure care staff are not overworked." The registered manager planned to increase the current level of staffing and service provision until the service had doubled in size. They felt this was the 'tipping point', beyond which it would be too big to provide the same quality of support.

Staff spoke very positively about the manager. They told us, "[Manager's name] often phones clients. They are so caring. It's not numbers, its people. They aren't money orientated; it's purely about clients getting what they need when they need it. I haven't heard a bad word from anybody about this company" and, "The manager is superb. I can't fault them. They are very passionate and caring. The clients love the fact that they go out and do the care. We are all building it together. The manager so appreciates that and thanks the staff daily."

Staff told us they were well supported. They received regular individual supervision and attended quarterly staff meetings where they were encouraged to contribute ideas about how the service could be improved and developed. They were supported in their professional development and felt valued for the work they did. One member of staff told us, "I couldn't work for a nicer team of people. They are so caring. So open and honest. They would do anything to make staff feel appreciated."

The registered manager and staff team were proactive in keeping their knowledge and skills up to date and using this knowledge to improve the lives of the people they supported. For example the registered manager had close links with the local authority and attended providers forums where information and ideas about best practice were shared. They were proactive in the national 'Proud to Care' campaign, which highlights the importance of care work and promotes careers in the health and social care professions. They told us, "I'm very keen to introduce new blood into the care sector. There are not enough of us."

Burton Homecare was working to develop constructive links with the community through its involvement with the Pride of Devon Awards where they had been a sponsor for the second year running. This award recognises the achievements of people who have contributed to and enriched their own communities.