Acorn Care Service Ltd

Acorn Care Service

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 28 November and 1 December 2016 and was announced. The provider was given 48 hours because the location provides a domiciliary care service; we need to be sure that someone would be available in the office.

Acorn Care Services provides personal care and support to people in their own homes. At the time of this inspection the agency was providing a personal care service to 47 people with a variety of care needs, including people living with physical care needs or memory loss due to progression of age. The agency was providing a service to people across the North, South and East of the Isle of Wight.

The agency had two registered managers each having specific management responsibilities. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run.

Recruitment procedures were in place and amended during the inspection to ensure staff were safe to work with people. There were sufficient numbers of care staff to maintain the schedule of visits. Staff told us they felt supported and received regular supervision.

We received positive feedback from people about the service. All people who used the service expressed great satisfaction and spoke very highly of the care staff and the way the agency was managed.

People told us they felt safe and secure when receiving care. Staff received training in safeguarding adults, knew how to recognise and respond to abuse and understood their responsibility to report any concerns.

People's risk assessments and those relating to their homes' environment were detailed and helped reduce risks to people while maintaining their independence. Staff were responsive to people's needs, which were detailed in care plans. People told us they had been involved in care planning and care plans reflected people's individual needs and choices.

People were cared for with kindness and compassion. People who used the service said their privacy and dignity were respected. People were supported to eat and drink when needed and staff contacted healthcare professionals when required. Staff had an understanding of consent and were clear that people had the right to make their own choices.

People felt listened to and a complaints procedure was in place. The provider sought feedback from people through the use of a regular reviews and a yearly survey. The results from the latest survey were positive. Systems were in place to assess and monitor the quality of the service people received.

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.

Recruitment procedures were in place and amended during the inspection to ensure staff were safe to work with people. People's needs were met by sufficient numbers of staff who were seen as reliable.

There were safe medication administration systems in place and people received their medicines when required. Risks to people's welfare were identified and plans put in place to minimise the risks.

Staff had received training in safeguarding adults and were aware of how to use safeguarding procedures. The service had a business continuity plan in case of emergencies.

Is the service effective?

Good

The service was effective.

Staff knew people's needs and records showed people received appropriate care, food and drinks.

Staff had an understanding of consent and how this affected the care they provided. People said staff always obtained their consent before providing care.

Systems were in place to ensure staff received training, support and supervision.

Is the service caring?

Good

The service was caring.

People and their relatives said staff were kind and caring. Staff had built good relationships with the people they provided care for.

Staff respected people's privacy and dignity. People felt involved in their care and were encouraged to be as independent as they could be.

Is the service responsive?

Good

The service was responsive.

People told us the care they received was personalised. People's needs were reviewed regularly to ensure this remained appropriate for the person.

The registered managers sought feedback from people and made changes as a result. An effective complaints procedure was in place.

Is the service well-led?

Good

The service was well led.

People and staff spoke highly of the service and the registered manager, who was approachable and supportive. Staff felt the service was open, honest and transparent.

There were systems in place to monitor the quality and safety of the service provided.

Acorn Care Service

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 28 November and 1 December 2016. The provider was given 48 hours' notice because the location provides a domiciliary care service; we needed to be sure someone would be in the office.

The inspection was carried out by one inspector and an expert by experience who had experience of caring for older people. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of 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 previous inspection reports and notifications we had been sent by the provider. A notification is information about important events which the service is required to send us by law.

During the inspection we spoke with 12 people who used the service, or their relatives, by telephone and visited two people in their own homes. We spoke with the two registered managers, office staff and six care staff members. We looked at care records for six people. We also reviewed records about how the service was managed, including staff training and recruitment records.

The service was previously inspected in February 2014 when we found no concerns.

Good

Is the service safe?

Our findings

People told us they felt safe and felt the agency provided staff who kept people safe. One person said, "Yes I feel safe", they added "I've sometimes gone out and forgot to let them know, they ring to check I'm OK." Another person told us "I feel very safe because I'm disabled and wouldn't manage on my own."

There was a recruitment procedure in place to help ensure staff were suitable for their role. One care staff member told us, "I had an interview, completed an application form and they did a police check." Another care staff member told us, "Before I started work I had to wait for the references and police check to come back." The recruitment procedure required applicants to provide an employment history and to undergo reference checks and checks with the Disclosure and Barring Service (DBS). The DBS helps employers make safer recruiting decisions. Although DBS checks were always completed, we found other aspects of the procedure were not always followed. Staff files included application forms and references. The application form requested staff to list their previous three employers not their full employment history. The registered manager amended this during the inspection. As part of the interview applicants were usually asked to account for any gaps in their employment although this had not always been recorded. Two references had been sought for all applicants although in two cases one of these may not have been the most appropriate person to provide a reference. We discussed these concerns with the registered managers who agreed they were an area for improvement and took action to make the necessary improvements.

People benefited from a safe service where staff understood their safeguarding responsibilities. A safeguarding policy was available and care staff completed formal safeguarding training for adults and children as part of their induction. Staff members were knowledgeable in recognising signs of potential abuse and the relevant reporting procedures. All care staff we spoke with stated they knew what to do if they suspected one of the people they supported was being abused or was at risk of harm. One staff member said, "I would contact the office immediately." Another staff member said, "I had to do this once, I told the office about my concerns and they took action to keep the client safe." The registered managers knew how to use safeguarding procedures and had reported concerns and taken action appropriately.

There were safe medication administration systems in place and people received their medicines when required. One relative said staff provided support with medicines and added "Any change I will be informed, they are on top of medication, charts are completed". Another relative explained that currently their relative was not always taking their bedtime medication. They told us care staff were asking the GP if the bedtime medication could be taken at teatime when care staff were present to supervise. This showed care staff took action to ensure people received all prescribed medicines. Staff received training about how to support people with medicines. After the training, the training manager assessed their competence and offered further training if necessary. Staff said their training had included how to complete the Medication Administration Records (MAR) and how to check the medicines they were giving were the correct ones. One staff member said, "I had initial training during my induction, then when I was out shadowing the care staff showed me and watched to make sure I knew exactly what to do." Completed MAR charts were returned to the office monthly to check medicines had been given as prescribed and any remedial actions were completed. Care plans included specific information about the level of support people required with their

medicines and who was responsible for collecting prescriptions. Care staff recorded the time they administered medicines which were required several times per day and which should not be taken too close together. Safe systems were in place and followed by care staff to support people who required eye drops or prescribed topical creams.

Assessments were undertaken to identify and manage any risks to people who received the service and to the care workers who supported them. These included environmental risks and any risks due to the health and care needs of the person. Risk assessments were available for moving and handling, use of equipment, nutrition, medication and falls. Where risks were identified there was guidance for staff as to how to reduce risks to people and themselves. For example, in one care plan we saw that two staff were required due to the need for the use of moving and handling equipment. A person told us staff always made sure they were wearing their personal alarm before leaving. This was to allow the person to request help in an emergency. Where care staff identified a person may be at increasing risk the registered manager had contacted health professionals for assessment and advice. For example, they had requested a joint visit with an occupational therapist (OT) when staff had identified a person was finding it increasingly hard to get up from their sofa. Environmental assessments were also conducted of the person's home. Office staff told us that if these identified people did not have smoke or carbon dioxide detectors they would contact the fire service who were able to arrange to fit these free of charge for vulnerable people.

Systems were in place to help keep staff safe. The registered manager said that the risks to staff working alone were assessed and where this indicated a higher risk action was taken. This could include providing two staff to attend calls and gave an example of where this had occurred.

People's needs were met by sufficient numbers of staff who people saw as being reliable. One person said they received a rota and added that if a call was not scheduled for their usual time "They will call to ask if this will cause any problems." The person added "They call if someone's ill and say you will have a different person [care staff member], they always let me know." A relative told us, "If they are going to be late or something has happened they will let me know most times." Everyone we spoke with told us care staff stayed the correct length of time. Staff said there was usually adequate travel time allowed between care visits. We saw staff allocation lists which allowed staff adequate traveling time between visits unless there was an unforeseen problem.

Care staff told us the time allowed for each visit meant they were usually able to complete all of the care and support required by the person's care plan. One relative said they felt more time was required in the morning. Office staff said that when care staff identified a need for more time on a regular basis they would approach the person or organisation who were paying for the care and request an increase. Where occasional extra time was required care staff said they were able to provide this and informed the office.

Acorn Care Service used a call monitoring system to ensure that all care calls were attended as required. On arrival at the person's home care staff logged into a care system using a randomly generated unique individual number which would only be accessible from the person's home. The same system was used at the end of the call to record the staff member was leaving. An up to the minute record of this was available in the office and on-call staff could access this on their computers. Alerts were also sent to on call staff by mobile phone so they would be aware of any missed calls when not viewing their computers. This meant managers were assured that care calls were not missed and that staff were safe.

Staffing levels were determined by the number of people using the service and their needs. The registered managers told us they would only take on more referrals if they were sure they had enough staff in the area the person lived. They gave an example of one area they covered where they had been unable to recruit staff

and said they had therefore not accepted any new referrals for this part of the island. Office staff were trained to provide care, and could help cover calls when required. One office staff member told us they were undertaking a tea time call on the day of our inspection as it was time specific and needed to be covered. Another told us how they had covered calls when required. Care staff told us the managers would support them if required, and had arranged for subsequent calls to be covered if they were unable to leave a person due to an urgent change in the person's needs. This showed there were arrangements and adequate staff available to ensure people received the care they required.

The service had a business continuity plan in case of emergencies. This covered eventualities such as severe weather or issues affecting the office such as power failures. It included procedures to follow and emergency contact details for key staff. For emergency planning purposes the service had been divided into locality areas and a named senior staff member was allocated to each. They were aware of staff living in their areas who could walk if necessary to the most vulnerable people. People had been risk assessed to identify those who would definitely still need a home visit, such as those living on their own, and other people who could be supported by phone calls if staff were unable to get to them. Most care staff were aware of the procedures if severe weather prevented the normal running of the agency. One care staff member said "I'm a walker so it would not make a lot of difference to me but they may ask me to visit some other people who live near me." This would mean that in the event of severe weather people and staff would not be placed at unnecessary risk.

Good

Is the service effective?

Our findings

People and their relatives responded positively to our questions about whether the service was effective. They said they would recommend the service to another person who needed support. Comments included, "I am very happy with them, all my carers are excellent. I look forward to seeing them every day."

People were happy with the way their care needs were met. People felt staff had received the training they required and had the skills and knowledge to provide the care and support they needed. One person said "They [care staff] are very good". Another person confirmed their care staff knew how to care for them and understood their difficulties. A relative told us they "Believe carers to be trained properly and they understand their [relatives] condition." Another relative said "The ground workers are very good, they inform me of everything, or the office will." People's health and personal care needs were met because staff knew people well and were able to describe how to meet their needs effectively. For example, one person was registered blind. Their care file directed staff to leave drinks on the windowsill and make sure they told the person where they were. One care staff member told us "If someone is unwell and we are with them and it's an emergency we would call 999 and then call the office. If we were not sure we would just call the office or the on call for advice." This showed staff knew what action they should take in emergency situations. A relative said care staff were "Attentive and will call me if anything is required or call the GP and let me know."

Care plans contained information about people's health and personal care needs and any action that was required to meet these. Care plans specified exactly what care and other tasks staff should complete at each call. Where people had several calls per day these detailed the tasks per call such as morning, lunch and bedtime calls. Staff recorded the care and support they provided and a sample of the care records demonstrated that care was delivered in line with people's care plans. Staff told us they were always told about the needs of the people they provided care and support for. Copies of care plans were held in people's homes meaning that care staff could consult these whenever required.

People usually received care from staff they knew. One person said, "They [office staff] try and keep the same ones going in." One person told us "It's usually the same ones." Other people also confirmed they usually had consistent care staff and were informed if there were to be changes to the planned roster. Two people showed us their rosters and confirmed that it was always a staff member they knew. People receive a roster each week informing them of who would be attending and when. Office staff said that when this changed, perhaps due to staff ill health, they tried to call everyone to inform them. One person said they received a roster and it was adhered to "As long as everyone else behaves before me", they added "They [office staff] ring and let me know." Duty rosters detailing which staff would be attending each call showed a good level of consistency of care staff for each person. People also said care staff completed all of the tasks that they should do during each visit and would ask if there was anything else needed before they left.

Most of the people we spoke with said either they or a relative prepared their meals. Those for whom care staff prepared meals for were happy with the way this was done. Care staff involved in the preparation of food told us they would always ask the person what they wanted. One person said "They make my breakfast and a drink, I tell them how I like it and they do it." Another person told us care staff "Make a sandwich for

my lunch as I wish." A relative told us "They leave [my relative] with a full glass of drink." We saw that when there were concerns that people may not be eating enough records of food and drinks people were offered and eaten were kept. Care plans contained information about any special diets people required and about specific food preferences. Care staff felt there was enough information about people's dietary needs and preferences in care plans.

People said they were always asked for their consent before care was provided. One person said, "When I'm really bad I say leave me alone. They don't push me." The person gave an example that they may not wish to get washed and dressed, but care staff may make a suggestion that they help and "It may make me feel better" the person also said "They are usually right." A relative told us care staff sought consent before providing care. They said "When I've been there they say 'do you want', 'would you like'." Staff confirmed they gained people's consent before providing care. One staff member said "I always offer a choice such as food or what to wear," Another care staff member told us "I ask them, even the ones who always say the same thing, they may change their mind." Care plans including data protection forms and permission to share information forms. These had been signed by people or where appropriate by a relative showing they consented to the care planned and processes used by the agency to support the delivery of care.

Staff were aware of the Mental Capacity Act 2005 (MCA) and had an understanding of how this affected the care they provided. The MCA aims to protect people who lack capacity, and maximise their ability to make decisions or participate in decisions that affect them. Staff described the process to follow if they were concerned a person was making decisions that were unsafe. Staff were aware people were able to change their minds about care and had the right to refuse care at any point. People told us they had been involved in discussions about care planning and were aware of their care plans and how the agency planned to provide their care.

People were supported by staff who had access to a range of training to develop the skills and knowledge they needed to meet people's needs. All care staff told us they had received an induction which prepared them fully for their role before they worked unsupervised. The training programme started with a three day induction where new staff completed a range of training in the agencies training room. This was followed by two days, or more where required, shadowing experienced staff. One staff member said they had completed shadowing and had been offered more if they felt they needed it. Another staff member confirmed the importance of shadowing, saying "I'd not done care work before so it was good to be able to start with another carer." One person explained how new care staff shadow experienced care staff "They [office staff] call and say, do you mind if someone comes to shadow." The person added "It gives you the chance to get to know them, I find it better if I talk to people face to face."

During their induction, staff completed a range of essential training and if they did not have a qualification in care commenced the Care Certificate. The Care Certificate is a set of standards that health and social care workers adhere to in their daily working life. Staff were positive about the induction and ongoing training they received. All staff told us they got the training they needed to enable them to meet people's needs, choices and preferences. One said "lots of training and they always say if we need any more then to ask." The agency had a training manager who also undertook direct care work with some staff. This provided the training manager with the opportunity to identify if care staff had any additional training needs. Should care staff identify a problem with meeting a person's needs the training manager would attend with care staff to see if a solution could be found. This meant care staff continued to have the skills necessary to meet people's needs.

Staff told us they receive regular supervision and appraisals which enhanced their skills and learning. One staff member said, "We have staff meetings monthly and there are spot checks." Spot checks were

unannounced and a member of the management team would observe the care workers care and interactions with people. They added "Sometimes office staff or [the training manager] works with you on two-staff calls." Another care staff member said, "I have a spot check about once a month." Records of supervision and spot checks were kept. These showed the process used was formalised and covered all relevant areas. When necessary, actions for improvement were identified and followed up.

Good

Is the service caring?

Our findings

People and relatives said staff were caring and they had a good relationship with them. They consistently reported staff having a kind and caring attitude, respecting dignity and maintaining people's independence. One person said, "There hasn't been one [care staff] where I have thought I don't want them to come to my home again." Another person said the care staff treated them with "Kindness, respect and dignity" adding "I've known them quite a while now." A third person said "It brightens my whole day." A relative told us, "They are kind considerate and understanding." When asked if care staff were caring and considerate another relative responded "All the time, I'm not aware otherwise." One person showed us a birthday card they had recently received from Acorn care service. They then showed us some flowers their main care staff member had given them for a birthday gift.

People were treated with dignity and respect. A person told us "When I come out [of the shower] they [care staff] put a towel on the chair for me to sit on, a mat on the floor to keep my feet dry, they put a big towel around my shoulders to keep me warm and another small towel on my lap." Everyone we spoke with responded that their care staff always treated them with respect and dignity. Care staff said they always kept dignity in mind when providing personal care to people. They described how they would close curtains or doors and ensure people were covered with a towel when having a wash. They told us this had been included during their induction training. A care staff member said "I keep people covered up as much as possible." Care plans contained guidance for staff as to how people would like their dignity to be maintained. One relative told us the care plan specified that staff should leave the person for some private time when they were using the toilet. People confirmed that staff gave them privacy when using the bathroom. All records relating to people were kept secure within the agency office with access restricted to only staff who should have need of access. Records kept on computer systems were also secure with passwords to restrict access. This would also help ensure people's privacy and rights to confidentiality were ensured.

People were encouraged to be as independent as possible. One person told us how care staff maintained their independence where possible and gave the following example; "They fill up a small kettle so I can make my own cup of tea". A relative said "[Name relative] tries and they [care staff] assist her". Where people could complete tasks they told us staff did not take over and they were encouraged to do what they could. Care staff knew the level of support each person needed and what aspects of their care they could do themselves. They were aware that people's independence was paramount and described how they assisted people to maintain this whilst also providing care safely. Care plans detailed what each person could do for themselves and what support they needed to achieve personal care and related activities such as shopping or meal preparation. One care staff member said they supported people to be as independent as possible encouraging them to undertake aspects of their own care where they were able to. One care staff member said "If they are able to wash their own face or clean their teeth then I give them the flannel etc. and encourage them to do it."

People said care staff consulted them about their care and how it was provided. One person explained that care staff would help them with additional tasks when required. They gave an example of when they had

wanted to change their bedsheets "They [care staff] would assist me if I'm unable to do it." Care plans showed people were involved in the planning and reviews of their care. Care staff respected people's rights to refuse care. They told us that if a person did not want care they would encourage but then record that care had not been provided and why. Care staff also said they would inform the office staff. People confirmed that if they did not want an aspect of care provided such as a shower then care staff respected their decision and would assist them appropriately. Care staff were aware of individual preferences as to how people liked to receive care. They told us they usually provided care for the same people which meant they were able to get to know the person. One care staff member described how this enhanced their ability to care for people.

The registered manager and office staff were aware that some people may have gender or other preferences regarding who supported them with personal care. They said that where people had a preference they would always meet this. One person told us "There was one carer who I couldn't make a contact with, Acorn know, they understood and don't send them anymore". The care coordinator was aware of people's preferences for certain care staff which was recorded within the call allocation computer system.

People hobbies and interests were recorded on the care plan; for example, one stated a person had been in the RAF and others included information about people's social contacts. Staff told us how they helped people care for their pets and this information was included in care plans. For example, within one care plan there was a reminder to the care staff to make sure the cat had food and water. One person told us how a plastic drawer in their fridge had been broken. They told us one of the care staff had told them they would bring some glue and mend it. Another person told us, "They [care staff] will come up with different ideas for me, for example: they found a phone number for the council regarding my bin collection." These examples showed care staff considered the needs of the person as a whole and did not just completed designated tasks.

Good

Is the service responsive?

Our findings

People received individualised care that met their needs. People we spoke with were satisfied with their care and the way it was planned and delivered. One relative said, "Yes, the regular carers know her." A person confirmed staff knew their likes and preferences. They said "Particularly my main carer. It makes a big difference." The person added "They pass messages to the next carer; they speak to them or pass messages in the book that way." Another person said "They know what I like, I like fresh fruit I don't have puddings." Where people requested a change to their care this was done. For example, one person told us "When my son comes I have to cancel the visit. They [office staff] say thank you for telling us. They don't mind as long as I let them know." A person told us "I have contacted them if I need to change anything, for example if I had an appointment. They are very, very good." Acorn care service was able to respond to changes in the person's needs, even if these were unpredicted. For example, an office staff member told us about one person whose relative who usually cared for them had to go into hospital as an emergency. Acorn Care Service had worked with the local authority and provided a staff member to stay with the person for two days until their relative returned. These examples showed the agency was able to respond to people's needs as and when they occurred.

One care staff member said, "If we are going to a client we have not been to before we can access the care plans before we go in so that we know exactly what we need to do." All care staff told us they felt the care plans provided them with all the information they required. Care plans reflected people's individual needs and were not task focussed. Copies of care plans were seen in people's homes allowing staff to check any information whilst providing care.

People confirmed they had been involved in planning their care and in reviews of their care plans. There was a system that care plans could be reviewed and updated as needs changed or on a regular basis. One person told us their "Care plan is reviewed every three months or thereabouts I think." A relative confirmed their involvement saying "There had been a review of the care plan with her present last time a few months ago, we went over everything." Records viewed confirmed this. Staff were clear that if they felt they needed extra time to meet a person's needs they would let the registered managers know. They were confident the office staff would make any necessary arrangements.

Acorn Care Service sought feedback from people or their families through the use of a quality assurance survey questionnaires. These were sent out to people every year seeking their views. The surveys for 2016 had been sent out shortly before our inspection. Everyone we spoke with confirmed they had received a survey. One person told us "I posted a survey yesterday; I found it amongst some papers." Another person showed us the survey which they had yet to return. A third person explained "I had a letter from the office at the beginning of November I haven't returned it yet though." Surveys which had been returned to the office were predominately positive. The registered managers said they were waiting until more had been returned and they would then analyse the responses. The registered managers said that if any of the returned surveys identified any issues, and they were aware of who had completed them as they were anonymous, then they would address the concerns directly. Otherwise they said they would review the agency systems to make improvements.

People or their relatives were aware of how to make a complaint or raise a concern about the service they received. Information on how to make a complaint was included in information about the service provided to each person and kept in the file held in the person's home. A person told us "I have only had one complaint and it was dealt with very well." They explained "I was not satisfied with one carer on one occasion and I was not prepared to have that carer again. This was dealt with." Another person said "I haven't had reason to complain", but confirmed they knew how to if the need arose. A relative said "If I had a complaint I would ring up the office but have no need – not slightly." Everyone we spoke with confirmed they knew how to complain and would do so if the need arose. People and relatives were confident that the registered manager took their concerns seriously and would take appropriate action in response. Should complaints be received there were appropriate procedures in place to respond to these including providing a written response to the complainant. The registered manager recorded complaints with investigations and outcomes documented.

Good

Is the service well-led?

Our findings

People and their families told us they felt Acorn Care Service was a well led service. One person said, "Yes I am very satisfied, I would not want to change." They confirmed they believed the service to be well led and that they would recommend the service to others saying "I am very satisfied with them [Acorn care Service] and my carers; they let me make decisions where sensible." Another person told us they were overall happy with the service saying they thought it was well led and that they had received care from Acorn Care Service "For over 12 years so I would recommend them." A relative told us they "Believe the service to be very well managed" and that they would recommend the service to others. They added "I would yes, I had a service before them and this one is 100% better." Another relative told us they were happy with the service and that they "Were always contacting the office and had received a good response."

Staff spoke highly of the agency and were pleased to work there. One staff member said "A friend worked for Acorn and told me it was nice working for them so I applied for a job with them." They confirmed that they agreed with their friend and found the registered managers approachable. Another care staff member told us they felt the management team were open and very approachable. They said that they felt able to "Raise issues or make suggestions" and that these were considered by the registered managers. Another care staff member explained how, when they were unable to work at short notice due to a family situation they had contacted the office and there had not been any problems. Their allocated calls had been covered and office staff had not made "An issue of it." Care staff described how they felt they always got a good response when they contacted the office and that someone was always available for advice or support at any time.

One of Acorn Care Services directors had been involved in setting up the agency and continued to be involved in monitoring the quality of the service and overseeing the financial aspects of the agency. Another of the directors was also one of the registered managers and usually worked daily at the office and provided some on-call support meaning they were fully involved in the day to day running of the agency. When necessary they would undertake a range of tasks including providing direct care. During the inspection both registered managers demonstrated an understanding of the agency and a commitment to ensuring people received a high quality service. The registered managers were supported by other office staff who each had specific organisational tasks allocated to them such as training, scheduling and care coordination. This meant there was a clear, visible management structure.

Designated area team meetings were held monthly. These allowed staff to meet to discuss any issues or concerns they had. The registered managers told us they had recently introduced focus groups for staff to look at how the service could be improved. They told us they would like in the future to also undertake some similar meetings with people or relatives who used the service. A suggestions box was provided in the agency office where anyone could post suggestions anonymously. The registered managers told us one suggestion had been received and this had been acted upon. This showed the management team were actively seeking the views of other staff and stakeholders about the service and how it could be improved.

The registered manager encouraged staff to be honest about their practice. They said that if staff were continuously making the same mistakes, their training needs would be looked at and staff would be

provided with additional support. The registered managers also considered how the agencies policies and procedures could be improved. For example, they identified that there had been a number of medicines errors and therefore had changed the medicines procedures and recording sheets. Staff had all received training in the new procedures and further support and guidance was provided to staff who felt they required this. The registered managers said they felt the new systems were more robust and safer. They identified that medicines errors had reduced as a result of the procedure changes they had implemented. Records showed that notifications about significant events were reported to CQC as required. There was a duty of candour policy in place which required staff to act in an open way when people came to harm and we saw this was followed appropriately.

The registered managers told us they kept up to date by reading the Commission's website, information from the provider organisation and through other professional websites. They also said they reviewed other information and research about health and social care and had attended relevant local training and local registered managers groups. The registered manager's told us about additional training they had completed, including a four day dementia course and end of life care training via the local hospice. One of the registered managers was undertaking a level 7 strategic business management course. This showed the registered managers were keen to ensure they provided a service that reflected current best practice.

There were procedures in place to monitor the quality of the service people received. All staff told us they received monthly unannounced 'spot checks' where a member of the management team would observe their care and interactions with people. The registered manager identified that unannounced 'spot checks' enabled them to ensure staff were following the correct procedures and people were receiving safe care. Records of care provided and medicines administration records were reviewed when these were returned to the office to ensure they were appropriately completed and to ensure people had received the care they required. On occasion the registered manager worked directly with care staff and completed training with them. They said this enabled them to fully monitor the way staff worked. The registered manager reviewed the staff allocation sheets prior to these being sent weekly to each person informing them of which staff would be attending to them and when. They said this helped ensure all calls were scheduled appropriately and with consideration of the person's wishes.

There were processes in place to enable the registered manager to monitor accidents, adverse incidents or near misses. These helped ensure that any themes or trends could be identified and investigated further. It also meant that any potential learning from such incidents could be identified and cascaded to the staff team, resulting in continual improvements in safety.