Bespoke Care At Home

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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

Our inspection took place on 28 November 2017 and was announced.

Bespoke Care at Home is a family-operated domiciliary care service based in Burnham. The service provides personal care to people in their own home. The service supports people in Burnham, Slough, Maidenhead, Windsor and surrounding areas.

At the time of our inspection, 51 people used the service and there were 40 staff.

People were protected from abuse and neglect. Appropriate systems were in place to safeguard people from the risk of preventable harm. People's care risks were appropriately assessed, mitigated and recorded. Recruitment practices and supporting documentation met the requirements set by the applicable legislation. We found appropriate numbers of staff were deployed to meet people's needs. People's medicines were safely managed. We made a recommendation about people's medicines management.

The service was compliant with the requirements of the Mental Capacity Act 2005 (MCA) and associated codes of practice. People were assisted 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. We made a recommendation about the required evidence for people's enduring and lasting powers of attorney.

Staff induction, training, supervision and performance appraisals were satisfactory and ensured workers had the necessary knowledge and skills to effectively support people. People's care preferences, likes and dislikes were assessed, recorded and respected. We found there was collaborative working with other community healthcare professionals. People were supported to maintain a healthy lifestyle.

The service was caring. There was complimentary feedback from people who used the service and relatives. People told us they were able to participate in care planning and reviews and some decisions. People's privacy and dignity was respected when care was provided to them.

Care plans were appropriate and contained information of how to support people in the right way. We saw there was a complaints system in place which included the ability for people to contact any office-based staff member or the management team. Some improvement was required in the way concerns and complaints were recorded. We made a recommendation about complaints management. Questionnaires were used to determine people's satisfaction with the care.

People had positive opinions about the management and leadership of the service. There was a good workplace culture and we saw the staff worked cohesively to ensure good care for people. Audits and checks were used to gauge the safety and quality of care. The provider met the conditions of registration and complied with other relevant legislation related to the adult social care sector.

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.

Effective systems were in place to protect people from the risks of abuse or neglect.

Appropriate risk assessments about people's care were completed and regularly reviewed.

There were sufficient staff deployed to meet people's needs, although people expressed there should be better continuity.

People's medicines were safely managed.

Lessons were learned and improvements made when things went wrong.

Is the service effective?

Good

The service was effective.

There were satisfactory levels of staff induction, training, supervision and performance review.

People's consent was obtained but further information was required about alternate decision-makers.

People's likes, preferences and care routines were well-documented.

The service worked well with other community healthcare professionals.

Is the service caring?

Good

The service was caring.

People told us staff were patient and kind.

People had developed positive relationships with staff.

People were encouraged to participate in care decision-making.

People's privacy and dignity was respected.

Is the service responsive?

Good

The service was responsive.

People's care was tailored to their needs.

People's care was reviewed and changed, when required.

People and relatives knew how to make a complaint.

The service actively sought and acted on people's feedback.

Is the service well-led?

Good

The service was well-led.

People and relatives told us the service was well-led.

There was a positive workplace culture with clear organisational goals and objectives.

Staff were involved in the operation of the service and had good access to the management team.

Relevant audits were completed to ensure safe, quality care.

The service was compliant with the conditions of the registration.

Bespoke Care At Home

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 service is a domiciliary care agency. It provides personal care to people living in their own houses and flats. It provides a service to older adults.

Our inspection took place on 28 November 2017 and was announced. We gave the service 48 hours' notice of our inspection visit because it is small and the registered manager is often out of the office supporting staff or providing care. We needed to be sure that they would be in.

Inspection site visit activity started and ended on 28 November 2017. We visited the office location on 28 November to see the registered manager and office staff; and to review care records and policies and procedures.

Our inspection was completed by two adult social care inspectors 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. Our Expert by Experience was familiar with the care of older adults who receive support in the community.

To gather information from people who used the service and their relatives, we completed telephone interviews. We spoke with eight people and two relatives. We reviewed information we already held about the service. This included notifications we had received. A notification is information about important events which the service is required to send us by law. We also checked for feedback we received from members of the public, local authorities and clinical commissioning groups (CCGs). We checked records held by Companies House and the Information Commissioner's Office (ICO).

We used information the provider sent us in the 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.

The inspection was informed by feedback from questionnaires completed by a number of people who used the service. This complimented staff on the care that was received.

At our inspection we spoke with the provider's main partner, registered manager, a care coordinator, two administrators and four care workers.

We looked at five people's care records, four staff personnel files and other records about the management of the service. After the inspection, we asked the registered manager to send us further documents and we received and reviewed this information. This evidence was included as part of our inspection.

Good

Is the service safe?

Our findings

People told us they felt safe. One person said, "Yes. Well, they are young ladies; they are no trouble with me." Another person told us, "Yeah they are lovely. They are always there, I know when they come. They are always careful and watch me to make sure that I am alright." Other comments included, "Yes I do (feel safe). They have the safe key numbers", "Yes, very safe" and "They come and they are excellent. They provide exactly what I have asked for. One or two are very keen..." Relatives also stated they felt the service was safe.

We found appropriate systems were in place to prevent abuse, neglect and discrimination to people. This included staff training, relevant policies and records of referrals to the local authority and investigations. Staff told us they received safeguarding training and updates and were confident that they would know how to access the service's safeguarding procedures if needed. Staff were able to provide definitions of different forms of abuse when asked and said that they would report any concerns immediately to the care coordinator at the office or the manager. All of the staff we spoke with were aware of whistleblowing policy. Not all staff were aware of contacts outside the provider if they needed to escalate a concern.

We looked at how the service assessed mitigated and documented people's care risks. We found there was good evidence of risk assessments in care files which had all been updated within the prior six months. For example, we saw these included environmental assessments about people's houses and mobility or moving and handling risk assessments. In addition there was a risk assessment action plan in each file with other identified risks such as pressure sores, risk of isolation along with actions to manage and mitigate each risk. We found these were not always very detailed and not always reflected in the care plan. For example, we saw one person was at risk of pressure sores which had been noted as a risk, and the action for staff was repositioning was required. However, we found this was not documented in care plan or daily schedule. In one care file we saw there were notes about weight loss in the monthly review but this was not reflected in risk assessments or the care plan section on diet and nutrition. Contact sheets showed the input and monitoring of health risks by a range of community healthcare professionals.

We checked the management of people's care records. We found all of the documents were updated within the last year and there were clearly documented reviews of care. We saw daily notes of care were handwritten; they were legible and sufficiently detailed, but sometimes task-focussed. Daily notes were all dated and signed by the staff member who provided the person's care.

We checked if staff would know what steps to take if they experienced people's behaviour that challenged them. Staff reported that they had received training in managing challenging behaviour and records of this was seen in staff files and on the service's training matrix. None of the staff interviewed had to manage any significant challenging behaviour but described ways of maintaining their own safety within the home environment. Staff told us they knew strategies for managing and verbal or physical behaviour which posed a risk to people or themselves.

People told us that sometimes there was not continuity in their care workers who supported them. One person told us, "No I get different ones most days." Another person said, "Yeah, not all the time. There are

about three (staff) that come to me that are regular." Other comments included, "They do change carers. One young girl has come along most of the week. This morning I had this young woman. I manage to survive on it. [I] can't guarantee that I will see the same carer again", "They've been changing a little bit lately. Changing people around. I have two that come in the morning. They always come together." Relatives told us that the care workers were usually the same staff members. One relative told us, "Mostly they are the same people." Another relative said, "She (the person who received care) had the same people. Carers sometimes turned up late a good few times. Sometimes an hour late. The office would say she (the care worker) was on her way."

We found there was an appropriate method in place for staff deployment. The registered manager explained that information was gathered from people, relatives and commissioners about a person's care needs. The care package was then designed to meet the person's needs and the allocated staff were based on a person's dependency. The registered manager explained the service also considered the capacity to start new care packages and described times when they had refused to take on people's support because of the inability to meet a person's needs. We found there was adequate travel time between calls, and in records we saw staff stayed for the required time period for scheduled calls. We were told there were occasionally inevitable delays in attending to people, which arose from traffic, roadworks or severe weather events. Where a care worker was running late, they notified the office and the care coordinator telephoned a person to advise the staff member was running late. There was a business continuity plan in place which covered sudden unexpected short staffing. Staff schedules were posted, e-mailed or hand delivered by staff to people so that they knew which care workers would attend their calls.

All staff interviewed reported that they always had enough time to complete their tasks and support people safely and effectively. They said that they were able to phone the office if they were delayed at a call and that they did not feel under pressure of rushed when delivering care. They were clear about their duties in relation to calls where two staff were required and said they would not attempt to deliver care or move people who required two carers if there was a only one at a person's house. This ensured risks to people of falls, slips or trips during personal care was reduced.

We looked at safe staff recruitment. We examined the contents of four personnel files. We saw appropriate checks for new workers were completed. This included verification of staff identities, checking any criminal history via the Disclosure and Barring Service, obtaining proof of conduct (references) from prior health and social care roles, and ensuring staff were able to perform their roles. We found the service employed only fit and proper staff to care for people.

People were protected from the risks of infection. We found there was good information on any infection prevention and control risks in people's care files and there was evidence staff had attended appropriate training, including food hygiene, on the office matrix. Staff told us they always used personal protective equipment when delivering personal care and had adequate supplies. The registered manager told us care workers visited the office to obtain gloves, aprons and alcohol hand gel and we noted a supply was available.

We checked whether people's medicines were safely managed by staff. Not all people who used the service required support with their medicines. We were told where possible, people were encouraged to maintain their independence and take their medicines without prompting. There was an appropriate medicines policy in place. Staff training consisted of online training, shadowing and a competency assessment by the registered manager or other senior care worker. The service obtained a list of medicines the person took at the commencement of the care package. Medicines were correctly administered by staff and there were no reported medicines incidents. Some medicines were only administered by district nurses, or other

community healthcare professionals. We checked medicines administration records (MARs) and these were satisfactorily completed and showed people received their medicines.

We recommend that the service reviews national best practice guidance regarding management of medicines to people in community settings.

We found lessons were learned and improvements were made when things went wrong. The registered manager showed us records at the office which documented items such as safeguarding referrals or allegations, complaints and concerns, health and safety and accidents or incidents. Staff were aware of the procedure to follow in the event of an accident or incident. They said that they would make a note of any accident or incident in their daily log and then complete the relevant form at the office. They explained they would document the incident which would be reviewed and signed by the care coordinator. Staff said that learning points and communication about accidents, safeguarding and other incidents were either sent out to them via email from the office or discussed at regular staff meetings.

Good

Is the service effective?

Our findings

We asked people whether their needs and preferences were used to formulate and guide delivery of their care. People provided mainly positive feedback about this. One person said, "Sometimes yes. I have always been told if I don't want a carer I only have to tell them. Another person stated, "I think so. I am a jolly person, we have quite a laugh." The next person said, "I much prefer females (staff) everyday. I don't like a male (staff member) anywhere near me." We checked with the service and the person received care only from female care workers.

We checked people's care plans to see if care achieved effective outcomes. We saw care plans were developed at the first home visit prior to the start of a person's service and included an assessment of risks and needs. Care plans were typed with a copy kept on file at the office and another at the person's home. We saw care files were paper-based, consistently organised and well maintained. This enabled staff to locate information about people easily and promptly. We found files were organised into sections which included a background; information including contacts for family, significant others, the person's GP and other healthcare professionals, medical conditions and support arrangements. The background also contained important information about people's equality and diversity. We saw this included people's social history and routines, ethnicity, religious and cultural information, preferred gender of their care worker and people's own views on their support needs.

People's care was documented on typed templates which covered all facets of their life. The templates for aspects of care included mental health, sleep patterns, communication, diet and nutritional requirements, mobility, any equipment used, financial issues or arrangements, access to property arrangements and medicines risks. The forms were tick-box based, but contained additional sections where staff could record additional information relevant to each person. We saw these contained information which was specific to the person who received the care. For example, we saw detailed information recorded for one person's likes and dislikes about food and drinks.

We found evidence of people's care package monthly reviews. These included home visit sheets, a care plan book review form that outlined any changes or issues and input from the person or relatives regarding the quality of the service. We saw these were well-maintained in all files, with a good level of detail on progress and any action required. All people's needs and choices were reviewed within the last month and on a rolling monthly basis so that there was a continuous review of care informed by daily notes, contact sheets and face-to-face discussion with the service's staff.

We asked people and relatives about the staff's knowledge of their personal care needs. There was mixed feedback about staff completing the care in a knowledgeable way. Comments about staff competency included, "Not all of them. I have tell them what to do", "Yeah, one or two of them have just started and they come together", "Yes, if I have any problems I just ring up the office. I have only had to ring twice in two years", "Yes, I am happy with them" and "Yes I think so." One person we spoke with felt staff were knowledgeable and skilled, but questioned whether they had completed formal qualifications in health or social care. They said, "Yes I think they did (provide appropriate care). I was shocked to find and confused to

find out that so few had NVQ (nationally-recognised) qualifications." We checked office records about staff training and support.

We reviewed the staff training matrix which was maintained electronically and this showed that the vast majority of staff had completed training in all mandatory aspects of their work including person-centred care, communication, privacy and dignity, food and fluid, mental health and dementia, safeguarding people at risk, infection control and first aid. However it was not possible to see from the matrix when the training had been delivered as there were no dates recorded, only that the topic was completed. We raised this with the registered manager and provider's main partner and they were receptive of our feedback. They explained they would change the staff training matrix to include the dates staff completed their training. Many staff had worked at the service for less than two years, so their training in the relevant mandatory topics was not outdated at the time of our inspection. Staff indicated that they received regular training in all relevant aspects of their work and gave examples of recent training such as fire safety, first aid and behaviours that challenge. Staff said that training was delivered via e-learning and face-to face practical training.

We found there was good evidence of induction training for new staff and there were certificates of completion for all Care Certificate modules, as well as competency assessments and sign off by the assessor and registered manager. There were records of shadowing on the electronic call record system. This is when an experience staff member works alongside a new staff member completing their induction. Staff said that they shadowed experienced staff for a period of a week but could extend this if they did not feel confident to work unsupervised. One staff member told us, "We are always asked if we feel ready and all new staff are offered more shadowing if they wish."

Staff reported that they had regular one-to-one supervision reviews with the care coordinator although the reported frequency varied between every six weeks to three months. This was confirmed by records in staff files which indicated one-to-one sessions approximately every six to eight weeks. The staff supervision matrix showed that most care staff had had completed two or three supervision reviews from June to November 2017. We saw seven staff had no reviews but six of these were new staff. Staff reported that they found supervision sessions useful as they could discuss people's care issues as well as raise any other queries or concerns in relation to their work or rotas. They commented that they were encouraged to undertake further training if they wished to progress, for example social care diplomas.

Records of staff supervisions were maintained in their personnel files. We observed these were very well documented with a clear record of the discussion and any action points. We saw there was evidence of input from both the care supervisor and the care worker. Supervision sessions used a template form that covered a general discussion, care reviews, personal development and health and well-being and recorded any action points and priorities for the next review.

People who used the service did not always require assistance with nutrition or hydration. We saw care plans contained a section related to dietary needs and nutritional status, although no formal method of recording the risk of malnutrition was used. Care plans specified if any assistance was needed with eating or preparation of food and recorded any particular food preferences, allergies or dislikes as well as mealtime routines. Staff told us any food or fluid monitoring would be managed by the district nurse in most cases. However, we noted that in one case a person's weight loss had been recorded on the monthly home visit review form but this had not been recorded in the care file. We reported this to the registered manager who stated they would take action to rectify this.

People we asked were positive about assistance from the staff with their eating and drinking. One person

commented, "They get my dinner ready in the evening and breakfast in the morning." Another person said, "Sometimes they do (prepare my meal) when my husband's not there. They (staff) are good, they get me cups of coffee." Other comments included, "(Staff) prepare food. I can manage my light lunch" and "Yes, they (staff) make me drinks and breakfast. They make food for me."

We found evidence that the staff worked well within a team to support people's care needs. For example, we saw records of regular spot checks of staff by care coordinators in all of the staff files reviewed. These occurred approximately every two months, with detailed information about the observed care, appearance, approach and attitude of care staff with people. Where care provision required improvement, supervisors and managers worked with the staff member to improve their practice to the level expected.

People were supported to maintain a healthy life within the community. When asked about this, people responded, "They help me shower", "If my legs are bad, they will tell me to ring the GP. They will tell me to ring the doctor if I am not feeling well", "I cut my shin on a tray. The carer wrapped it up" and "They [put] cream [on] me. When they were washing me they were concerned, so they called 111 (NHS advice)."

Staff told us that they worked closely with other healthcare professionals such as district nurses, GPs and emergency services as needed. We found there was very good evidence in care records of multidisciplinary team working with contact sheets maintained within the care file. These showed dates and details of input from the other healthcare professionals. Staff we spoke with knew where to find the information in the person's file and what type of communications to record. We also noted e-mails and printed notes from the GP and others were within people's files for care workers to read.

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.

We saw there was good evidence of consent to care and support in people's care documentation we reviewed. We found each file contained a consent form to agree to share information with staff as needed and an agreement to care arrangements set out in care plan. These were very clear and signed and dated by the person, except in one case where the legally-nominated representative had signed. We noted there was a section in people's care plans with documentation about do not resuscitate (DNACPR) decisions and any power of attorney. One care file showed evidence of an advocate although this only indicated a name and contact number and not the advocate's role in assisting with a person's decision-making. Although the registered manager said that they requested a copy of any registered enduring or lasting power of attorney documentation, they were unable to show us any examples. They said they had sent e-mails to people and relatives asking for a copy of the documents.

We recommend that the service obtains details of registered enduring or lasting power of attorney documents via the Office of the Public Guardian.

Staff explained that they always sought consent from people before offering to assist with personal care or other daily support. Two of four staff interviewed said that they had received training in the MCA but were

unable to clearly describe the meaning of mental capacity and none could recall any of the principles of the Mental Capacity Act. We provided this feedback to the registered manager at the time of our inspection.

Good

Is the service caring?

Our findings

We asked people whether they were treated with kindness, respect and compassion. People gave complimentary feedback. One person told us, "Yes, majority (of the staff) make sure I am alright; all the time they make sure I am ok before they leave. They do that little bit extra, and might clean the kitchen before they leave. Another person told us, "Yeah they are all right. They are quite good really. They are courteous. There is no 'monkey business' going on." Other comments included, "Oh yes, very nice, as I say we all have a good laugh" and "Yes they are. Even my sister has made comments about how happy I am with them." Relatives also felt the service was caring. One stated, "Yes they knew she (the person who used the service) did not want carers in. I had to get her in a routine and get her used to it. They were kind to her." Comments from our pre-inspection questionnaires also demonstrated people received caring support. One person wrote, "All the carers are kind and lovely. Always enjoy a nice chat and laugh when they are helping me. I look forward to them coming each day." Another person stated, "I have only been with the agency a few months. I have been satisfied so far."

Care workers we spoke with said they understood the needs of the people they cared for and could access information by reading the individual care plans, although they did not receive any briefing document or information before supporting someone for the first time. When we asked, staff were able to clearly describe the needs, routines and risks of those they had supported that day.

People felt that the staff knew their routines, likes and dislikes well. A person told us, "Yeah, some of the carers know me...I have different carers." Another person said that the care workers treated them with courtesy, which is what they liked about their care package. A third person told us they enjoyed communicating with the care workers. The care records confirmed the person liked conversations. They told us, "It's useful conversation. While the meal is being cooked in the oven for 20 minutes." Relatives we spoke with agreed that the staff from the service knew people's needs.

We found people were able to have a say in how their care was planned and provided. We saw care plans were developed by the care coordinators in liaison with people during the initial assessment visit. We found this enabled the person and their relatives to provide input on the care and support required. We saw there was a good level of person-centred information in care plans on preferences, routines, social like and activities or hobbies enjoyed.

People's privacy and dignity was protected and promoted. Staff described the methods they used to ensure that they respected people's privacy and dignity such as closing doors and curtains when delivering personal care and ensuring that people were covered up as far as possible. All of the people and relatives we spoke with told us they were satisfied with their privacy and dignity. One person said, "Yes, they leave me alone to shower (in privacy)."

Good

Is the service responsive?

Our findings

People told us they felt they received person-centred care tailored to their individual needs. Regarding care plans, one person stated, "She (a staff member) came a few weeks ago to make sure. They had got all the things that were wrong with me. She checked on my tablets. Someone from the office." Another person felt they could tell the service what they preferred. They told us, "Well I tell them what I would like." The next person we spoke with knew about their care plan and confirmed staff ensured the care was unique to them. The person said, "Yes I have a care plan. They put down what I have to eat. Yes, it's updated regularly. Someone (a staff member) comes in and updates the book." Relatives also confirmed that care was personalised and checked by the service. One relative stated, "We have ticked forms I think. We had someone on Sunday morning who...asked about things." Another relative said, "Yes I was (involved); it was a very basic conversation."

We saw there was very clear evidence of regular reviews by care coordinators via monthly home visits and care plan reviews. We found each one was recorded on separate forms with details of any changes, health issues or other circumstances relevant to care and support. These forms were seen in all care files inspected and demonstrated a meaningful and thorough review of care delivery and need almost every month with evidence of input and feedback from each person. In addition there was a contact sheet in each file which recorded any relevant contact with healthcare professionals or family members, so that there was a continuous update of person-centred information if circumstances or needs changed.

People were aware of how to make a complaint, and a small number had raised concerns with the management of the service. One person said, "Yeah I have complained. I remember my relative wrote (to the service). Another person said "No, it (the service) all works pretty well. I am pleased with it. I am 86." A third person told us, "No I haven't made a complaint. I did mention it was not on to be an hour and something late."

There was a complaints system in place at the service. This was not always responsive. The complaints file contained a copy of the complaints procedure which was satisfactory, with clear timelines and accountabilities for verbal and written complaints. There was a contact number for the Local Government Ombudsman in the event of non-resolution of a complaint. The complaints policy required that all verbal complaints are recorded in the person's care file but there was no central log for complaints. One of the care files had a copy of an e-mail sent to care staff in relation to a verbal telephone complaint from the relative of one person regarding their care, but there was no documentation of how or whether the complaint was resolved or whether any apology had been issued.

The registered manager told us that there had only been two official complaints but was unable to show us relevant documentation. We were told that both complaints were resolved via phone or e-mail. The registered manager acknowledged that the service should have maintained a better central record of all complaints notified to the service.

We recommend that the service reviews the complaints system.

We found that satisfaction surveys were conducted twice per year and saw the results and analysis of the latest survey in July 2017. There were 14 responses received out of 39 questionnaires sent. There was a well-documented analysis of the results from the surveys. We noted the questionnaire consisted of 17 questions related to the quality of care and service, with a four-point scale for answering each (very satisfied to very unsatisfied). The analysis of results indicated a high level of satisfaction across most aspects of the service. For example more than 75% of respondents gave the maximum satisfaction score for most questions. The survey showed that people's largest dissatisfaction was with care visits being late and keeping them informed of changes to times of calls. The analysis report also included actions to improve shortfalls. We saw the service noted that plans were put in place to ensure people were informed of call delays or changes. However, there was no information to measure to ensure this or how it would be monitored.

Good

Is the service well-led?

Our findings

The provider is required to have a registered manager as part of their conditions of registration. 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. At the time of our inspection, there was a manager registered with us.

People's and relatives feedback about the management of the service was varied. Some people and relatives felt the service was well-led, whilst others were complimentary. For example, one person said, "They are alright. They are bit strange how they send their staff around and send them miles away. I am not sure what is happening over the Christmas period as they did not say." Another person commented, "I don't have a lot to do with them. What I do is quite nice. If I do have a problem they sort it out straight away. Very friendly. Easy to get hold of people in the office." Another person commented on the registered manager and said, "She seems quite concerned about everything." Other comments included, "Very good. I would recommend the agency they are very good" and "I asked to speak to someone I knew in the office (when I wanted to speak with management)."

There was a positive workplace culture at the service. We observed this during our site visit at the office. In addition, all members of the staff interviewed were very positive about working at the service and all claimed to have a good level of job satisfaction with a supportive and open culture. Some mentioned that the service was extremely supportive to individual staff when needed, accommodating personal circumstances and difficulties with genuine empathy and flexibility. We received complimentary comments from staff about the management team. These included, "Supportive", "Follows things up", "The [registered manager] is setting an example for us all", "The managers try to encourage us", "they have a good rapport with carers; they send us appreciation letters, texts and e-mails" and "They are open to listening to us."

Staff were expected to ensure that the care provided to people was of a high standard. The registered manager and provider's main partner explained the aims of objectives of the service to us, and these were also reflected in the statement of purpose (a document required by the legislation setting out key information). The registered manager explained their role in managing staff performance, what they did when care was below the service's expectations and how they could drive staff improvement. Appropriate procedures were in place for investigations, staff grievances and disciplinary matters.

The registered manager told us that a number of meetings were used at the service to ensure vital information was shared with relevant staff. The meetings were also used as a conduit for sharing experiences and explaining new concepts or gathering staff feedback. We saw there was a senior care workers' meeting each week and we looked at the notes form a recent meeting. Issues discussed included any injuries or accidents, changes to people's care packages, feedback from relatives and people who used the service and checks on the quality of care.

A quarterly staff meeting was held which allowed all care workers not based in the office to attend and meet

with other staff. We looked at the minutes from the October 2017 meeting. We saw discussions about medicines safety, on call arrangements and recognition of good practise. Staff confirmed that the service held regular meetings in the office at which learning and experiences could be shared, and any concerns or issues discussed. Some commented that staff meetings were organised so that care staff could meet beforehand so that they could discuss any items that they wanted to include on the agenda before senior staff were present. This ensured that there was input and interaction at all levels and effective two way communication.

A small number of quality audits and checks were used to gauge the safety and quality of care. These were completed approximately one every six weeks. One audit involved a senior care worker reviewing people's care documentation. At the time of our inspection, the registered manager explained this was happening for all people who used the service. When we asked why everyone's documentation would be audited so frequently, the registered manager explained that this was commenced at the time of them commencing in their role. The registered manager explained they had examined the care documentation at the time and found it required improvement. As all of the care documentation was reviewed every six weeks since they started in post, changes were made to the care documentation in consultation with staff. They pointed out some of the changes to us and explained some further planned changes. The registered manager told us the frequency of the documentation checks would remain unchanged, but the number of files checked would be changed and they would ensure all files were audited at least every six months.

Services are required to comply with the duty of candour regulation. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' in relation to care and treatment. It also sets out some specific requirements that services must follow when things go wrong with care and treatment. This includes informing people about the incident, providing reasonable support, providing truthful information and providing an apology (including in writing).

The service had an appropriate duty of candour policy in place which gave clear and specific instructions for management to follow when the duty of candour requirement was triggered by safety incidents. When we asked the registered manager, there were no notifiable safety incidents which triggered the duty of candour requirement. The registered manager's knowledge of the duty of candour principles was good, and we recommended they further increased their understanding of the concept and associated processes. They were receptive of our feedback.

The service ensured that people had access to the information they needed in a way they could understand it and were compliant with the Accessible Information Standard. The Accessible Information Standard is a framework put in place from August 2016 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. We were told some staff could speak languages other than English. We found people's support plans also included information about how to effectively communicate with them.

Confidential information about people who used the service and staff was protected. At the time of the inspection, the provider was registered with the Information Commissioner's Office (ICO). The Data Protection Act 1998 requires every organisation that processes personal information to register with the ICO unless they are exempt. We found the service complied with the relevant legislative requirements for record keeping.

There were times when the service was legally required to notify us of certain events which occurred. When we spoke with the registered manager, they were able to explain the circumstances under which they would send statutory notifications to us. We checked our records prior to the inspection and saw that the service

had notified us of relevant events. At our inspection, we found a change to the provider's registration type was required. We explained this to the registered manager and provider's main partner. After our inspection, the service commenced an application to change the type of service.