Royal Mencap Society

Mencap - North Hampshire Domiciliary Care Agency

Inspection report

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Date of inspection visit:
05 January 2017

Date of publication:
22 February 2017

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 5 January 2017 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.

Mencap North Hampshire 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 25 people with a learning disability and a variety of care needs. The agency was providing a service to people across the north of Hampshire the majority of whom were living in houses providing 24 hour care and support for several people.

The agency had a registered manager. 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. The
registered manager oversaw the running of the service and was supported by service managers who were allocated a geographical area to manage. At the time of this inspection a temporary manager was managing the service whilst the registered manager had some planned extended leave from work.

Staff understood how to protect people from abuse and were responsive to their needs. People were protected against the risk of abuse, checks were made to confirm staff were of good character to work with people. There were sufficient staff to meet people's diverse needs and people were supported to take their medicine as prescribed.

Risk assessments and support plans had been developed with the involvement of people and their representatives. Staff had the relevant information on how to minimise identified risks to ensure people were supported in a safe way. Staff understood people's needs and abilities and knew people well.

Staff were provided with a comprehensive induction and ongoing training to support the people they worked with.

The provider understood their responsibility to comply with the requirements of the Mental Capacity Act 2005. Staff knew about people's individual capacity to make decisions and supported people to make their own decisions. People's needs and preferences were met when they were supported with their dietary needs and people were supported to maintain good health.

The delivery of care was tailored to meet people's individual needs and preferences. The provider actively sought and included people and their representatives in the planning of care. There were processes in place for people to express their views and opinions about the service provided.

People, relatives and staff spoke highly of the management. There were systems in place to monitor the

quality of the service to enable the manager and provider to drive improvement.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

People's needs were met by sufficient numbers of consistent staff. Recruitment procedures were followed to ensure staff were safe and suitable to work with people.

Staff had received training in safeguarding adults and were aware of how to use safeguarding procedures.

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.

Is the service effective?

Good

The service was effective.

Staff knew people's needs and records showed people received appropriate personal and health care. People were supported to receive the food and drink as and when required.

Staff were aware of the Mental Capacity Act 2005 (MCA) and 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 were involved in decisions about their care and lifestyle and that they 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 and people's needs were reviewed regularly to ensure this remained appropriate for the person.

The manager 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 were encouraged to share their opinion about the quality of the service to enable the provider to identify where improvements were needed.

Staff understood their roles and responsibilities and were given guidance and support by the management team. Systems were in place to monitor the quality of the service provided.

Mencap - North Hampshire Domiciliary Care Agency

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 5 January 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 inspection was carried out by one inspector who was supported by three other inspectors who undertook visits across Hampshire to seek the views of people about the service.

Before the inspection, we checked information we held about the service and the service provider, including previous inspection reports and notifications about important events which the provider is required to tell us about by law.

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

The agency was last inspected in November 2013, when we did not identify any concerns.

Good

Is the service safe?

Our findings

People told us they felt the agency provided staff who kept them safe whilst providing them with personal care. One person said, "Yes I'm safe". Another person also said they felt safe. We saw other people were relaxed and at ease with staff when we visited them in their homes. A family member said, "Yes I think [relative's name] is safe, I'm not worried about that". Another family member said, "The staff try to keep [relatives name] safe, there have been some problems with another person they live with but that's not the staff's fault." A third relative told us staff had acted correctly when they had had concerns about their family member's safety and they felt the situation was managed well.

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 staff we spoke with knew what action they should take if they suspected one of the people they supported was being abused or was at risk of harm. One staff member said, "I would make sure the person was safe and reassure them. Then I would check the details and contact my line manager or the police depending on what had happened." They added that they would also make a written record of everything and were aware of who to contact either "higher up" in the organisation or externally such as social services. Other staff also said they would contact their line manager and be guided by them. The manager knew how to use safeguarding procedures and had reported concerns appropriately. They were able to discuss the actions they had taken and would take if various situations arose.

Most people receiving a personal care service required 24 hour support with staff present at all times. Staffing levels within houses were determined by the number of people living there and their needs. We were told there had been issues with recruitment and therefore Mencap North Hampshire had been using external agency staff to ensure all shifts were covered. A family member told us they had seen a reduction in the number of agency staff who were supporting their loved one. They said, "There used to be lots of different people, some I only saw once, but now it seems more consistent". Other family members expressed similar views and felt that there had been improvements in the consistency of care staff in the months prior to the inspection.

The manager, a service manager and care staff told us staffing levels had improved in the months prior to the inspection and fewer external agency staff were now used. For example, in one house we visited there was one full time staff vacancy which was filled by external agency staff. The same agency staff were used wherever possible and the service manager confirmed these were staff who were known to the people who lived there. A care staff member told us how important it was for people to be supported by staff they knew and confirmed they worked with a regular permanent staff team and regular agency staff. This was also confirmed by duty rosters viewed. We looked at staff duty rosters in another house. These also showed that regular agency staff were used as much as possible. Another care staff member said of the house they worked in, "Regular agency who know the ropes", and added, "Consistency [of staff] here is very good". Other care staff told us the use of agency staff was well managed and had reduced in recent months. The

service tried, as much as possible, to ensure that experienced regular or agency staff induct new agency staff into the service.

Risk assessments were undertaken for any risks to people 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. Where needed, risk assessments were also available for moving and handling, use of equipment, nutrition, medicines and falls. Where risks were identified there was guidance for staff as to how to reduce risks to people and themselves. For example, one person had been identified at risk of choking. A Speech and Language Therapist (SaLT) had undertaken an assessment and provided advice about what would be safe for the person. This information was included in the person's care plan and staff were able to describe how meals for the person were prepared. Another person had poor eyesight and there was a risk assessment in place to keep them safe. This directed care staff to keep her path clear, the lights on and advise the person when out in the community of any potential risks to their safety. Risk assessments were reviewed every six months and where necessary amendments were made.

There were safe medication administration systems in place and people received their medicines when required. Care plans included specific information to direct care staff as to how people should be supported with their medicines. Care files contained a list of medicines people were prescribed. During induction care staff received training about how to support people with medicines. Following training, staff competency was assessed and this was reassessed every year. Staff said their training had included how to complete the Medication Administration Records (MARs) and how to check the medicines they were giving were the correct ones. A care staff member confirmed this and said they had recently completed their annual competency assessment. They told us the competency assessment included questions, and "if you couldn't answer them you could be re-trained". People's medicines were checked at each staff handover so that errors would be picked up quickly. A service manager told us that if an error occurred a 'conversation' was had and staff may be referred to complete training again. Care staff informed us that when an agency staff member had made a medicine error this had been reported to the agency and the staff member had been re-trained.

We observed staff offering 'as required' (PRN) medication for a person who was experiencing pain. The procedure used ensured the person understood what they were having and that they wanted to take the medicine. The person said, "It will make my back better", showing they had understood and staff signed the MAR after the medicine had been taken. We saw medicines were stored in locked cabinets either in people's bedrooms or in a central secure cupboard. Medicine records viewed were all fully completed. Medicines stock checks were carried out to ensure they were available when needed which staff told us this was, "So we never run out". Safe systems were also in place for prescribed topical creams to ensure they were used safely.

Recruitment procedures ensured staff were suitable to work with vulnerable people. One staff member told us, "Before I started work I had to wait for the references and police check to come back." As part of their recruitment procedure potential staff were introduced to some people to enable their interactions to be assessed. A service manager told us people were asked for their views about applicants and if they would be happy for the staff member to support them. Staff files included application forms, full work history, records of interview and appropriate references. Checks had been made with the Disclosure and Barring Service (criminal records check) to make sure people were suitable to work with vulnerable adults and that staff members were entitled to work in the UK.

The service had a business continuity plan in case of emergencies and within individual houses we were told of their plans for emergencies. This included eventualities such as the risk of severe weather which may

prevent staff arriving for work. All staff were clear that they would not leave a house until their replacement had arrived. Staff also told us that if severe weather were forecast they would make sure there were adequate supplies of food in place. For other emergencies, such as fire there were personal evacuation plans in place, systems to detect fires and arrangements for staff as to what they should do.

Good

Is the service effective?

Our findings

People and their relatives felt care staff were effective and they were confident in their ability to meet people's needs. A relative told us, "The staff do seem to be able to look after [relative's name] and understand his needs". Relatives also said they would recommend the service to another person who needed support.

People's health and personal care needs were met because staff knew people's needs and were able to describe how to meet them effectively. For example, when we visited one house a person was not feeling very well. They had had a recent fall and was experiencing some pain in their shoulder. Staff were aware of this and understood the reasons why the person was not their usual self. The person had seen a relevant medical professional and was being provided with regular pain relief. We saw staff checked whether they were in pain and offered pain relief. Staff also offered a heated 'wheat bag' which the person clearly appreciated. The person was using a walking aid in the home and records viewed showed they had seen health professionals regarding their falls. Staff were knowledgeable about the actions to take to prevent further falls and risks were included in community and house safety plans. Staff members told us they were also booked to attend moving and handling training to update their knowledge in response to the person's falls.

Care files contained a 'grab and run' sheet which included people's personal details, medicines, next of kin and a hospital passport which included essential individual information about the person and what they like and dislike. Staff told us this had been useful for a recent hospital admission and said, "I try to put in how they are at home and all their equipment so they know because if they went in [to hospital] they would not be able to tell the staff there". These would help ensure people's needs would continue to be met if they required urgent medical care within another setting.

Staff were aware of the action they should take if a person was unwell. Care staff confirmed they had received first aid training and additional training to meet the needs of any specific health needs individual people may have. Care plans contained information about people's health and personal care needs and any action that was required to meet these. Care staff were able to describe the individual support a person with epilepsy required and confirmed they had completed training to help them understand the condition. Staff recorded the care and support they provided and a sample of the care records demonstrated that care was delivered in line with the care plan.

People said they were always asked for their consent before care was provided. One person said, "Yes, they [care staff] ask me". Staff said they gained people's consent before providing care. One staff member said, "I always ask first and tell them what I'm doing". People's care plans instructed staff about ensuring people's consent was gained and included consent forms which had been signed by the person or their relative.

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. Where people had some impairment in their decision

making or cognitive ability care plans contained information as to how they could be supported to make decisions and which decisions they could make. For example, one care plan informed staff that the person could understand clear simple directions. Staff were aware of the actions they should take if a specific decision was required which the person was unable to make. For example, one person required a medical procedure. Staff were completing a metal capacity assessment and had sourced pictures of the procedure to help explain this to the person. The staff member told us, "I know they can make choices better with pictures". The discussion with the person had had been documented. The staff member said, "I don't think she (person) did understand what is going to happen to her so I am asking someone else to check with me how much she could retain". The staff member was clear they would pass on the outcome to the healthcare professionals who would complete the MCA process. Staff described the process to follow if they were concerned a person was making decisions that were unsafe and that they would contact the office for guidance. Staff were also aware people were able to change their minds about care and had the right to refuse care at any point.

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. People and their relatives were confident that care staff had the skills to care for them effectively. One relative said, "They [care staff] seem well trained". Newer care staff told us they had received an induction which prepared them fully for their role before they worked unsupervised. New staff completed a range of theoretical and practical training which was followed by up to two weeks shadowing experienced staff. A new staff member said, "I had seven shadow shifts then was asked if I felt ready. I said I didn't feel confident yet, so I had a couple more shadow shifts until I felt I knew everything I needed to know". Other newer staff also confirmed they had a thorough induction including shadow shifts.

Care staff and managers told us external agency staff completed an induction. Although records of these were not available in one house we visited there were detailed induction files for new and agency staff seen in another house. These included the procedures for managing medicines and individual medicines protocols for each person at that house. Read and sign sheets were in place and completed by staff to confirm they had read and understood the guidance. There were detailed handover records between shifts. The format of these records had been expanded to reflect the learning that had taken place following errors in relation to the management of medicines. This meant that all staff whether permanent or external agency would have all the information they required to meet people's needs.

During their induction permanent new staff completed formal training and 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. Workbooks were seen showing staff received a comprehensive induction which was relevant to their role. Staff were positive about the induction and ongoing training they received. One care staff member said, "Lots of training, very good induction". Other longer term staff also told us they received ongoing training to maintain their skills and knowledge.

People were supported by staff who had supervisions (one to one meetings) with their line manager and an annual appraisal. One staff member said, "There are supervisions with my area manager about every three months". Records of supervisions and appraisals showed the process used was formalised and covered all relevant areas. When necessary actions for improvement were identified and followed up. An area manager said, "We have a 'shape your future' appraisal system this includes four formal sessions per year about how we want to progress and our goals". A care staff member told us they were currently on the provider's 'You've got talent' programme which gave staff access to training they could bring back to the service. They told us they were developing their skills and knowledge around community involvement. They added that they felt well supported and the 'You've got talent' programme was helping them to develop knowledge and skills and identify other career opportunities within the company.

People told us staff helped them prepare their meals. Care staff involved in the preparation of food told us they would always ask the person what they wanted. We observed staff interacting positively and respectfully with people, supporting them with choosing and preparing lunch. Where necessary records of food and drinks people received were kept such as when there were concerns the person may not be eating enough. Care plans contained information about any special diets people required and about specific food or drink preferences. For example, where people required their meals in a soft format we saw that they were receiving suitable meals. We saw menus were available to show recommended meal options (soft and moist consistency) were planned and a staff member added, "It would be unfair for the other person [living in the same house] to have to follow this". Staff ensured that the need for a special diet did not prevent the person enjoying usual activities. Staff told us how they supported one person to have meals out. They said, "We know of places that will liquidise food or we can take the liquidiser to do it for [name person]" Each person had a separate menu to ensure their needs and preferences were met. Staff knew what people liked to eat and one person told us they liked fish and chips and a roast dinner. We saw both were included on their menus.

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 a kind and caring approach relating to staff having a caring attitude, respecting dignity and maintaining independence. One relative told us how care staff had organised a birthday party for a person and invited family and friends to celebrate with the person.

We saw people appeared comfortable with staff and they told us they liked the staff. One person said, "They [care staff] are nice". In another house both people told us they liked their care staff. A relative told us, "[name person] always seems happy when they come to collect her [after a visit to relatives home]". Another relative told us how the agency was caring towards them as well as their relative. They told us, "When I phone they also ask how I am". A care staff member said, "[Name person] prefers personal care with someone she knows and trusts. She used to struggle to have a shower and hair wash but now she comes and asks me if she wants one". This showed the person had developed a trusting relationship with care staff.

People were treated with dignity and respect and supported to enjoy a lifestyle of their choosing. One person was having their nails painted and care staff told us they did this as, "[Name person] likes them looking nice". We saw that people were supported to be appropriately dressed and well-presented and that conversation between care staff and people was easy, comfortable and familiar showing that staff had a good knowledge of people's likes and dislikes. It was evident all people were supported to have active lifestyles and were members of various social groups, clubs and colleges within their local community. Care staff facilitated additional events and we saw photographs of people enjoying activities including karaoke, archery and off road buggy rides.

Care staff said they always kept dignity in mind when providing personal care to people. Care staff described how they would close curtains or doors and ensure people were covered with a towel when having a wash. Care staff at one house told us female staff was always available to provide personal care for the ladies who lived there. Information about any gender preferences of care staff was included within care plans. People said care staff consulted them about their care and how it was provided. One person told us, "They ask me". Care plans were detailed and showed people and relatives were involved in the planning and reviews of their care.

People were encouraged to be as independent as possible. Care staff in one house told us how they supported people to be involved in household chores. They told us, "[Name person] likes to join in and help, [name another person] less so. When we took over from the previous providers it had been run very much on the staff doing the work, food appeared and plates were taken away and washed up and we've tried to change that ethos so that [names people] are involved in that process and do as much as they can". Other care staff told us how they included people in day to day routine activities and tasks. We were shown decorations people had made, photos of people participating in food preparation and enjoying other activities. A care staff member described how they supported one person to be involved in food preparation by, "Hand over hand support to whisk desert". This showed that staff ensured people were fully involved and encouraged to be as independent as possible.

Staff were knowledgeable about people and told us about the things people enjoyed doing, what they liked to eat, what was important to people and their communication needs. Care staff were organised into area teams and told us they usually worked with the same people. This meant they had had opportunities to get to know the person as an individual and what mattered to them. We saw care plans contained detailed information about people's communication methods. Where people were unable to express themselves verbally, information about how they may express themselves in other ways was included. Care staff described how they could identify if people were in pain through behaviours; how another person preferred pictures to make choices and said, "[Name person] will take you by the hand and point so you can understand". We saw care staff communicating effectively with people demonstrating that they valued people's views and opinions. The service had links with and knew how to access advocacy support if this were required.

People's spiritual needs and wishes were met and we saw that some people were supported to attend Church on Sundays and a local community group for singing in the week. A care staff member told us they had come in to work on Christmas Eve so that two people could attend the carol service at the church. The staff member told us they had done this because they knew, "Church was important to them [people] and [name person] loves all the carols". The staff member told us they had done this, "Although it was not their planned activity time, I know both people would really enjoy this".

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 helped ensure people's rights to privacy and confidentiality were maintained.

Good

Is the service responsive?

Our findings

People received individualised care that met their needs. People we spoke with were very satisfied with their care and the way it was planned and delivered. One person said, "They help me". One relative told us, "These are the best staff [person's name] has ever had". Relatives told us they had been included in discussions about how their loved ones care should be provided and that reviews were held to which they were invited.

One care staff member said the "Care plans are good, everything is there that needs to be to provide care." Another care staff member said the "Care plans are really useful". Care plans reflected people's individual needs and were not task focussed, they included guidance for staff as to how people should be supported in various situations. For example, in one care plan there was information as to how a person may show they were anxious and advised staff to interact with the person and support them to move to a quieter area. Where people required specific equipment, such as for moving and handling, we saw this was available for people and detailed information as to how it should be used was included within care plans. Should people have specific medical needs such as epilepsy or diabetes, care plans included information from external health specialists and actions for staff to take. 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. One person told us, "We have reviews here at my home". A relative said, "Communication between us all [agency, relative and person] is very good and we have reviews together. We've just recently done one and [name person] was fully involved". There was a system that care plans could be reviewed and updated as needs changed or on a regular basis. Records were kept of monthly meetings between people and their keyworker. A care staff member told us, "[Name person] was not that interested in this". However, the staff member had completed the review with observations and activities and described what the person had liked and disliked and what they were finding difficult. For example, the person was missing a club they had attended that had ended so the staff member was trying to help find a new one that was suitable.

Care staff had the skills required to support people whose needs could change suddenly or who may become distressed in some situations. Care staff told us about one person who could place themselves and others at risk. However, they told us this had never prevented the person from going out. Staff were trained to redirect the person. Another person had anxiety which could limit their activity. Staff explained how they "Always try to promote and offer choice and work in small incremental steps". This person told us they were happy with the staff and the activities they took part in. Staff described how they adapted to meet the specific needs of individual people. For example, they told us about "[Name person] doesn't like crowds, noisy big environments. We've tried a number of things to help her with shopping trips likes using headphones with music on and having a CD with music". Another care staff member told us how they had supported a person to attend hospital in an emergency including staying with the person until the early hours even though they had not been due to work that evening.

A record of care provided was kept for each person. Records were kept daily including where necessary,

food and fluid intake, medicines, bowel habits, and personal care provided. Staff told us these were important because for example, one person was at risk of poor hydration so the daily fluid intake record was used to ensure they drank a sufficient amount. There was a targeted amount on the sheet. Records showed this was mostly achieved demonstrating that staff were supporting and encouraging the person to have enough to drink. Daily records showed people occasionally required a change to their routine, perhaps due to ill health. Staff responded to this and ensured care was provided to the person. There was a running record of significant events or any areas of concern which were then highlighted in the communication book for staff to follow up. For example, when a person fell this was recorded and identified for follow up in the communication book which was completed. We saw people were receiving care as detailed in their care plans such as in respect of meals, fluid intake, support with moving about and other specialist equipment required.

The provider sought feedback from people or their families through the use of a quality assurance survey questionnaire. This was sent out every year seeking their views. The results we looked at were positive. The manager told us the questions were formed from the 'have your say group'. They said, "This is a group for service users we support and they meet every six weeks. We said to them we need to send our surveys but want to know what you would like to be asked about and then included this information on our surveys which were sent out."

People and their relatives were confident that care staff or members of the management team took their concerns seriously and took appropriate action in response to any issues raised. A person told us, "I would tell [name care staff member]" in response to the question about what they would do if they were unhappy about something. Information on how to make a complaint was included in information about the service provided to each person. The complaints procedure in a suitable format was displayed in people's rooms describing the steps to take and included pictures and contact numbers of the people to contact. Complaints information also included a pre-addressed envelope and complaint card people could send to the manager. The manager told us they would then arrange to visit the person to discuss their concerns. Area managers were frequent visitors to the various houses people lived in. We observed they had a good understanding of each person and that people felt relaxed with area managers. This would mean that people could also raise issues directly with area managers.

Should complaints be received there was a process in place which would ensure these were recorded, fully investigated and a written response provided to the person who made the complaint. One relative told us that they had raised a complaint to the service manager and that the concerns raised had been addressed. Other relatives told us they had not had reason to complain.

Good

Is the service well-led?

Our findings

People, relatives and staff spoke highly of the leadership and felt the service was managed well. One person told us the manager had visited them and, "shook my hand". One relative told us were aware of how to contact the service manager or manager if they needed to do so. Another relative told us "I usually go to the care staff but could speak to the manager if I needed to". Relatives and staff all said they would recommend the service to a relative or friend in need of this type of care.

All the staff including the manager told us people came first and it was apparent from our conversations with people, their relatives and staff that this philosophy governed the day to day delivery of care. Staff described the services values as being to "Promote choices", "Support people to make every day valuable" and to ensure people were able to live "Their life as they wanted to".

Staff spoke with enthusiasm about their work. One staff member told us they enjoyed their work and said, "This is the first job where I have ever looked forward to actually going to work". Another care staff member commented, "This is the best job I've ever had. Morale is so good at this service." A third care staff member who had not previously worked in care told us they were, "Really enjoying their change in career".

There was a clear management structure in place. Staff were aware of the line of accountability and who to contact in the event of any emergency or concerns. Staff felt well supported within their roles and described the management as approachable. A temporary manager had been managing the service since June 2016 when the registered manager commenced a period of extended planned leave. A staff member said of the temporary manager, "He has really got to grips with the service and made positive changes". They added, "He is approachable, understanding and supportive with a calm manner. He gets us to share ideas as a patch and support each other". A service manager responsible for a designated geographical area told us that as a manger they felt it was very important to be visible in the service. It was clear from our observations that they knew people well. For example, they were able to talk knowledgeably about people's needs and current health issues and people appeared comfortable with them when they offered support.

Care staff were also positive about the service managers and the manager. A care staff member told us things had improved since the summer with more regular staff and less use of agency staff. They told us there, "Are monthly team meetings to discuss any issues and the service manager visits daily if possible or is available by telephone". The staff member told us about other support and we saw 'out of hours' contact numbers and details of the nearby 'buddy' house were in place. Another care staff member said of the management team, "There are no problems with them, they listen to us". A third care staff member told us about an issue they had raised with management and that a meeting had been arranged. These examples showed that staff felt able to raise issues with the management team and felt that they were listened to.

Feedback on the quality of the service provided was sought from people, relatives and staff on an individual and on-going basis. The manager told us they were organising 'forum days' which included inviting people and their care staff to a venue to talk about challenges and service development. The manager told us people and care staff were divided into separate groups who then 'fedback' to each other about their

discussions and agreed actions or ways forward. The manager told us they also undertook regular visits to each geographical area to monitor the service. They spoke to people and staff to gain their feedback and carried out spot checks on records. They told us some of these visits were planned and some were 'unannounced' and that they spoke with people and observed how staff interacted with people. This enabled them to have oversight of the service and monitor whether or not they were following the provider's policies and procedures and meeting people's needs.

The provider was using internal quality assurance frameworks to govern the running of the service and were completing internal audits. Audits are a quality improvement process that involves review of the effectiveness of practice against agreed standards. Audits help identify shortfalls in service provision so the provider can take action to drive improvement and promote better outcomes for people. Regular audits were completed in relation to each aspect of the service such as people's medicine administration records, care plans, staff supervision and training. The manager told us that service managers were required to record information about events that had occurred in the service, such as how many accidents and incidents there had been and whether any care plans had been reviewed. These were recorded on a weekly basis using the provider's on-line quality assurance system.

The manager told us the system flagged up any areas of concern to them such as if staff training was out of date, whether a person was due to have a review of their care or whether a safeguarding referral had been made. They explained this information was also analysed by the provider's quality team to enable them to identify any themes or trends which were then fed back to the registered manager for them to take action. The manager gave an example of how the quality assurance systems had been used. There had been a number of medicine errors and the manager had requested the quality team to undertake a review. This had identified actions and as a result the number or errors had reduced.

The provider and manager showed a commitment to continuously improve the service people received. The provider had a national quality team who undertook assessments of either the whole service or elements of the service. The provider also had a national learning and development team who provided managers with information and feedback to help ensure services followed 'best practice' guidance as far as possible. The provider's computer system recorded up to date information about people such as the dates of care plan reviews or when people had seen their GP's. This and other information such as complaints, safeguarding, and risk management linked into the service improvement plan which service managers completed monthly. The manager explained they monitored the completion of action plans on a monthly basis. The quality team also gave advice as to how to minimise the risk of the incidents re-occurring.

The manager told us they were supported by the provider's organisational structures. They explained the provider had a dedicated human resources team who could give advice and guidance in all matters relating to managing people and that they and their service managers had attended a selection of the provider's training courses related to managing the service such as recruitment and selection.

There was an open and transparent culture. 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. The manager was clear about how and when it should be used. Staff were aware of the provider's whistleblowing procedures and told us they would not hesitate to raise any concerns they had about poor or unsafe practice. One staff member told us they, "Would speak out", and would be confident the manager would act. They explained if they felt they had not been listened to they would go to the local authority with their concerns. Staff were aware of different organisations they could contact to raise concerns. For example, care staff told us they could approach the local authority or the Care Quality Commission if they felt it was necessary.