

Optalis Limited

Short Term Support and Rehabilitation Team

Inspection report

Town Hall
St Ives Road
Maidenhead
Berkshire
SL6 1RF

Tel: 01628621981
Website: www.optalis.org

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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

About the service:

- The service's office is based in the Maidenhead town hall. Care is provided in the surrounding areas.
- The service provides personal care to adults who are recovering from hospital admissions, receiving rehabilitation or need short term personal care until alternative care arrangements are made.
- The service is operated by a trading body of a local authority. They work in partnership with another local authority to provide personal care to people in the local community.
- At the time of our inspection, 25 people used the service and there were 46 staff.

People's experience of using this service:

- The provider had made good improvements to the service since our last inspection on 7 November and 8 November 2017.
- Staff received better training, induction, supervision and support so they could effectively perform their roles.
- The registered manager had resolved issues surrounding the recording, investigation and analysis of incidents and accidents.
- Governance of the service had improved. Sufficient better checks and audits were carried out to determine the quality of the care. The provider had promptly acted on some areas already identified for improvement.
- People and relatives told us the staff were kind, friendly and dedicated. They said staff knew people's needs well.
- The provider used their staff, leaders and management team to achieve compliance with the regulations. The provider had provided the necessary support to enable satisfactory organisational change.
- The service met the characteristics for a rating of "good" in all the key questions we inspected. Therefore, our overall rating for the service after this inspection was "good".
- More information is in our full report.

Rating at last inspection:

- At our last inspection, the service was rated "requires improvement". Our last report was published on 21 December 2017.

Why we inspected:

- All services rated "requires improvement" are re-inspected within one year of our prior inspection.
- This inspection was part of our scheduled plan of visiting services to check the safety and quality of care people received.

Follow up:

- We will continue to monitor the service to ensure that people receive safe, compassionate, high quality care. Further inspections will be planned for future dates.

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.

Details are in our findings below.

Is the service effective?

Good ●

The service was effective.

Details are in our findings below.

Is the service caring?

Good ●

The service was caring.

Details are in our findings below.

Is the service responsive?

Good ●

The service was responsive.

Details are in our findings below.

Is the service well-led?

Good ●

The service was well-led.

Details are in our findings below.

Short Term Support and Rehabilitation Team

Detailed findings

Background to this inspection

The inspection:

- We carried out our inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. Our inspection checked whether the provider was 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.

Inspection team:

- Our inspection was completed by two 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 had knowledge about personal care of adults within the community.

Service and service type:

- 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 younger and older adults and people with dementia.
- The service is required to have 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. At the time of our inspection, a manager was registered with us.

Notice of inspection:

- Our inspection was announced.
- We gave the service 48 hours' notice of the inspection visit because staff were often out of the office supporting staff or providing care. We needed to be sure that they would be in.

What we did:

- Our inspection was informed by evidence we already held about the service. 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 asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make.
- We spoke with 11 people who used the service and a relative.
- We spoke with the provider's head of regulated services, the quality lead, registered manager, assistant manager, care coordinator, three care workers, a physiotherapist and an occupational therapist.
- We reviewed seven people's care records, six staff personnel files, audits and other records about the management of the service.
- We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Is the service safe?

Our findings

Safe – this means we looked for evidence that people were protected from abuse and avoidable harm

People were safe and protected from avoidable harm. Legal requirements were met.

Systems and processes:

- All the people we spoke with told us they felt the personal care they received was safe.
- During staff induction, staff received face-to-face safeguarding training. Staff attended a corporate induction which included safeguarding. There was a whistleblowing policy, which staff had a copy of and could access on the provider's computer systems.
- Staff repeated training in safeguarding each year. This included children and adults, as staff completed care calls where children may be present in a person's house.
- The registered manager and assistant manager had completed advanced training in safeguarding.
- The registered manager and assistant manager knew what constituted safeguarding, and openly reported any allegations or actual issues to the local authority.
- Where the staff performance fell below the standard of care expected, the management team dealt with these by taking appropriate action to prevent recurrence.
- The registered manager sent us statutory notifications to inform us of any events that placed people at risk.

Assessing risk, safety monitoring and management:

- The service received referrals for new care packages via telephone, as commencement of personal care might be required out of hours or at short notice.
- Referrals were received from acute and community hospitals, GPs, community nurses, paramedics, social workers, hospices and relatives.
- When the referral was received, it was triaged to ensure capacity and eligibility for the personal care. Where there were not enough care hours available, people could be placed on a waiting list and priority would be given to people considered at high risk.
- The service coordinators visited people in their house or other setting and completed a "first visit pack". Out of hours the person might be visited by a care worker in the first instance. Risks would be recorded by the care worker so that the package could commence immediately. This was then communicated to the service coordinators who would log more extensive information in the electronic care system.
- Initial assessments included how to access people's houses. The service identified that key safes were being left open inadvertently, but this was due to newer style key safes. The service designed signs and placed them on the back of people's front doors as an aide memoire, to ensure the key was safely stored.
- The service had changed the risk assessment tool to include more detailed information. Risk assessments included health, safety and environmental risks. This had improved the assessment and mitigation of risks to people to ensure, as far as possible, their protection from avoidable harm.
- The registered manager had completed research to ensure the risks assessments were comprehensive. They had referred to best practice and liaised with other providers of community care in the review and development of their risk assessments.
- Other risk assessments included "moving and assisting", which ensured people who required manual

handling had appropriate measures in place to prevent slips, trips and falls.

Staffing and recruitment:

- People provided positive comments about the staff deployment. They said, "[Staff] appeared in no rush" and "[The care workers] stayed until they had done all that was required."
- The service used a master rota that was developed for a two-week period. This recorded any staff that were off on leave and indicated how many care hours were available at the time, which assisted with planning the calls.
- The registered manager stated the service coordinators could 'level out' the staffing deployment across different days of the week, to ensure that people received their care on time and that calls were not missed.
- Slots of 30 minutes were the minimum amount of time allocated to people's calls, but this was increased if the person's needs were more complex, for example when a person commenced end of life care.
- The service coordinators monitored calls during business hours to ensure that people were allocated care workers, that calls were on time and changed schedules where necessary. The service was responsive to people and relatives changing their care calls at short notice. Calls could be cancelled on request.
- The service coordinators triaged telephone calls during business hours where there were any issues with people's support calls. They would problem solve any detected issues, for example the person refused to receive care from a particular staff member, care workers involved in traffic incidents or breakdowns and short-notice sick leave.
- Personnel files contained all the necessary pre-employment checks which showed only fit and proper applicants were offered roles.
- Recruitment practices were strengthened since our last inspection. This included checking information in the files was complete, and setting out the files to enable finding documents quicker.
- Checks included asking for a full employment history, checking the reasons why staff had left their previous roles, obtaining a criminal history check from the Disclosure and Barring Service and obtaining references from prior employers.
- Interviews of staff were robust, and often carried out by two senior staff. The information required by the relevant regulation and schedule was stored in the staff personnel files.

Using medicines safely:

- Risk assessments were completed for the safe management of people's medicines at the beginning of a care package.
- The service had added a place to record allergies more prominently on the risk assessment. This followed a suggestion at our last inspection.
- The service had liaised with the local clinical commissioning group lead pharmacist to revamp the medicines management policy. This was due to be released to the staff as the final version and the pharmacist had already commenced training with some staff.
- Staff received face-to-face and practical training in the safe management of medicines. Staff repeated their training approximately every 12 months.
- The service coordinators checked staff competency with medicines management every three months. This check was part of a wider observation of the staff member's role expectations and performance.
- The pharmacist had suggested the medicines competencies for staff be completed separately to the quarterly general observations by the service coordinators. The registered manager was receptive of this, and planned to implement a new competency form designed by the pharmacist.
- The service recognised the need to ensure people remained as independent as possible with taking their own medicines. The staff only prompted the person or administered the medicines when the person needed assistance.
- Due to the nature of the service, and the short time of the entire care package, relatives also often managed people's medicines.

- The medicines administration record (MAR) contained most of the necessary information for administration of people's medicines. There was information about the types of medicines (creams, eye drops and ear drops) the person received, reasons for not administering, allergies and boxes for staff to sign and date when medicines were given.
- We noted that a list of medicines a person took was not on the form. The registered manager explained the pharmacist had suggested improving the medicines recording, and provided a new MAR for introduction into the care packages. This would improve the information available to people, care workers and health and social care professionals. This would also help the service if they liaised with GPs or pharmacists about people's medicines.

Preventing and controlling infection:

- Since our last inspection, training for staff in infection control was separated from all other training. This meant that staff received dedicated training in infection prevention. Training included education and observation of staff handwashing practices in a simulated environment.
- The service had organised for better handwashing facilities to be installed at the office location. This meant staff coming back to the office could wash their hands more regularly.
- Six staff 'champions' received advanced training in infection prevention and control. This included the assistant manager who led the other 'champions'. The number of staff appointed in the role was so that there was a wide range of staff available across the service to help educate and mentor all the other employees.
- The infection prevention 'champions' had presented education at staff meetings, informed practice using research and best practice and examined the infection control status within people's homes.
- The service purchased copies of the NHS's "preventing infection workbook" and staff were required to read the book, complete the quizzes and pass the learning. A certificate was produced and stored in the staff member's training records. The staff member then kept the workbook for future reference and refreshing their knowledge.
- Staff had access to personal protective equipment, including disposable gloves, aprons, gowns and shoe covers. The stocks were kept at the site office as well as various outlying locations so that there was ready accessibility.

Learning lessons when things go wrong:

- Since our last inspection, the service had introduced a tracking sheet to manually record incidents as they occurred. At our prior inspection, there was difficulty in keeping a tally of the number of incidents as they were stored in individual people's electronic care records.
- Once a month, the registered manager reviewed all of the logged incidents to identify themes and trends. For example, they checked whether there were staff or system related root causes to repeated incidents.
- Blank incident forms were kept to hand by the care workers. If an incident or accident occurred, the care worker completed the form and returned it to the office.
- The management team triaged the incident forms as they came into the office. They checked that people's safety was maintained and conducted any investigations or further enquiries.
- If any actions were required, the registered manager wrote to the affected person (or family member) and provided an explanation and an apology.
- A folder containing all relevant information to each incident was maintained so that there was ready access to information, as required.
- The service also logged incidents and accidents that involved staff but did not relate to people who used the service. For example, in September 2018 there were two car accidents that involved staff and verbal abuse of a care worker.

Is the service effective?

Our findings

Effective – this means we looked for evidence that people's care, treatment and support achieved good outcomes and promoted a good quality of life, based on best available evidence

At our last inspection on 7 November and 8 November 2017, this key question was rated "requires improvement". We found there was a fragmented system for recording and storing people's care records. There were insufficient levels of staff training, supervision and performance appraisals. At this inspection, we found the service had taken steps to improve the effectiveness of people's care. Therefore, the rating for this key question has increased to "good".

People's outcomes were good, and their feedback confirmed this.

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:

- The management of people's care records had improved.
- Assessments of people's needs we saw were comprehensive, expected outcomes were identified, and care and support regularly reviewed.
- We saw notes kept in people's homes were now linked to electronic care plans, and each was changed as needs changed. The provider was actively working towards a system that was entirely electronic and could print out notes in people's homes.
- Staff applied learning effectively in line with best practice, which helped lead to good outcomes for people and supported a good quality of life.

Staff skills, knowledge and experience:

- The service had increased the focus on staff support through better inductions, more supervisions and comprehensive appraisals. This meant staff had the necessary knowledge, skills and experience to perform their respective roles.
- Staff we spoke with were competent, knowledgeable, and skilled and felt supported by managers to develop.
- Staff undertook online training in areas such as safeguarding and the Mental Capacity Act 2005, infection control, first aid, and safe medication management. Face-to-face training was completed by staff for safe moving and handling of people. They told us they valued this and it helped them improve the quality of the care they provided.
- We saw staff were encouraged to undertake additional, non-mandatory training, which they felt was of good quality and helped them meet the needs of people.
- New staff had completed an induction to the service and a probation period. Each time they were introduced to a new person, they were given comprehensive information and met the person with a care co-ordinator, who knew them well.
- We saw staff had regular supervision and appraisal, which they told us they found useful. They also described spot checks in people's homes, which focused on issues such as professional appearance, confidentiality, manual handling, bathing, infection control and food preparation.
- Each of these was seen to be helpful and were recorded in detail and staff gave examples of positive

changes to care resulting from each of them.

- We saw supervision, appraisals and training needs were cross-referenced with people's needs.

Supporting people to eat and drink enough with choice in a balanced diet:

- Care plans we saw showed us people had choice and access to sufficient food and drink throughout the day; we saw care co-ordinators checked if staff ensured snacks and drinks were always available.
- Where people were at risk of poor nutrition and dehydration, plans were in place to monitor their needs closely and professionals were involved where required to support people and staff.

Staff working with other agencies to provide consistent, effective, timely care:

- We saw risk assessments had been carried out in people's homes and changes negotiated if necessary.
- Staff told us technology and equipment was used effectively to meet people's care and support needs.
- Staff worked with the physiotherapists and occupational therapists employed by the provider and local NHS Trust. Together they ensured that people received the care and support they needed to achieve their rehabilitation goals.
- The service also worked with GPs, palliative care teams and social workers when people required additional care, needed transfer to a care home or received end of life care.

Supporting people to live healthier lives, access healthcare services and support:

- Where people required support from healthcare professionals, we saw this was arranged and staff followed guidance provided by such professionals.
- This was confirmed by healthcare professionals we spoke with.

A relative told us staff were vigilant with people's health conditions. They said, "They [care workers] spotted that mum had cold hands...they spotted that she had a urinary infection and involved the doctor."

Ensuring consent to care and treatment in line with law and guidance:

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 to receive care and treatment with appropriate legal authority. We checked whether the service was working within the principles of the MCA.

- Staff assumed people had the capacity to make decisions, unless they assessed otherwise. Some people who used the service lacked the capacity to consent to care and treatment.
- There was evidence of mental capacity assessments, when needed, and their outcomes.
- Staff gave us examples of ensuring people were involved in decisions about their care and showed us they knew what they needed to do to make sure decisions were taken in people's best interests.
- Staff told us people were supported to have maximum choice and control of their lives and were supported in the least restrictive way possible.

Is the service caring?

Our findings

Caring – this means we looked for evidence that the service involved people and treated them with compassion, kindness, dignity and respect

People were supported and treated with dignity and respect; and involved as partners in their care.

Ensuring people are well treated and supported:

- People provided consistently positive feedback about staff and the service.
- Comments included, "Staff are brilliant and lovely...they are amazing and lovely", "I think they're wonderful; don't know what I would have done without them. They're fantastic", "Helped me cope; couldn't have managed when I came out of hospital", "Ladies lovely; what they did for me was great", "Very pleased, impressed, grateful, very helpful and encouraging to do things for myself. Happy for them to stop when I have achieved my purpose. I was able to do things that they wanted me to do" and "They were wonderful, lovely, so helpful, so friendly...very friendly."
- Staff spoke about people with kindness and compassion.
- Each person had some life history and wishes briefly recorded in care plans and managers and staff told us they used this to get to know people and to build positive relationships with them.
- Care co-ordinators showed us they knew people and the staff assigned to them, and regularly reviewed care plans.
- Staff we spoke with knew people's preferences and used this knowledge to care for them in the way they wanted.
- We saw some people and their relatives had given very positive feedback to staff and to managers. This included statements such as, "It's an amazing team", "I received absolutely wonderful help", and "You [the service] have been an absolute inspiration to me."

Supporting people to express their views and be involved in making decisions about their care:

- Staff showed us they supported people to make decisions about their care and knew when people needed help and support from their relatives.
- Where necessary, they sought external professional help to support decision-making for people.
- We saw staff involved other professionals in ensuring effective palliative care.

Respecting and promoting people's privacy, dignity and independence:

- Staff we spoke with showed genuine concern for people and were keen to ensure people's rights were upheld and that they were not discriminated against in any way.
- People's right to privacy and confidentiality was respected.
- People were afforded choice and control in their day to day lives. Staff were keen to offer people opportunities to spend time as they chose and where they wanted.
- Staff gave us examples of working well with relatives to provide care in an integrated way, for example with relatives carrying out some tasks and staff others.

Is the service responsive?

Our findings

Responsive – this means we looked for evidence that services met people's needs

People's needs were met through good organisation and delivery of care.

The provision of accessible information:

All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.

- We saw managers were working towards ensuring an advanced level of adherence with Accessible Information Standard principles. The registered manager showed us multiple examples of easy-read and symbol-based communication aids which were produced by the service and being implemented (where necessary).
- The care records documented that the service identified and recorded communication impairments, and steps were implemented to ensure information was provided to people in a way they could understand it.
- Some people had very complex needs, and staff recognised the need for alternative methods of communication with them.
- Care documentation explained what communication aids such as glasses, hearing aids or sign language people required as part of their daily lives.

Personalised care:

- People said they were encouraged with their independence. Comments included, "They encourage and suggest a different way or method to do things" and "I was encouraged. They gave tips on how to do this and that...watching me do it."
- Staff showed us they knew people's likes and dislikes. They used this knowledge to care for people in the way they wanted. For example, care plans had very clear details around how a person preferred to be supported with personal care and tasks necessary to obtain desired outcomes, and actions carried out were recorded by staff and available to managers.
- We saw from care plans and from talking with staff that people were empowered to make choices and have as much control and independence as possible, including in developing care, support and treatment plans. Relatives were also involved where they chose to be and where people wanted that.
- People's needs were identified, including those related to protected equality characteristics such as age, disability, ethnicity and gender, and their choices and preferences were regularly reviewed.

Improving care quality in response to complaints or concerns

- There was an appropriate complaints management system in place. Complaints were handled in the correct way.
- Staff knew how to provide feedback to the management team about people's experiences.
- Staff knew how to raise complaints should they need to. They told us they believed these would be listened

to and acted upon in an open and transparent way by management, who would use any complaints received as an opportunity to improve the service for people.

- We saw complaints made by a relative had been looked at promptly and carefully by managers and a clear action plan put in place to prevent similar issues arising again.
- We saw monthly "service user feedback" forms had been sent out and issues raised by people were addressed by managers.

End of life care and support:

- Some people received end of life care in their own homes. The service supported people well during palliative care.
- Staff worked proactively with other health and social care professionals to ensure people had a pain-free, dignified death.
- The service assisted to start care packages as soon as possible, so that people could experience their end of life in their home, rather than in a healthcare setting.
- Staff knew the techniques and skills necessary to ensure symptoms associated with end of life conditions were managed and people were comfortable.

Is the service well-led?

Our findings

Well-led – this means we looked for evidence that service leadership, management and governance assured high-quality, person-centred care, supported learning and innovation and promoted an open, fair culture

At our last inspection on 7 November and 8 November 2017, this key question was rated "requires improvement". We found people's accidents and incidents were recorded in different ways and not able to be readily collated, analysed and learnt from. Systems used to ensure good governance of the service required improvement. At this inspection, we found the service had taken steps to improve the governance of people's care to ensure quality outcomes. Therefore, the rating for this key question has increased to "good".

The service was consistently managed and well-led. Leaders and the culture they created promoted high-quality, person-centred care.

Planning and promoting person-centred, high-quality care and support, and how the provider understands and acts on duty of candour responsibility when things go wrong:

- Since our last inspection, the service has implemented a comprehensive system of audits to monitor safety, quality and make improvements when needed.
- A quality audit of all aspects of the service was completed by the provider in April 2018. The extensive findings clearly set out the actions required to ensure full compliance with the provider's objectives, and all applicable law. For example, one finding was more first aid kits were needed and staff required information about their locations. The registered manager had acted and completed this task stemming from the audit.
- An audit of key question "well led" was completed in November 2018. This showed the extensive list of standards were met. This ensured that people's care, and the governance of the service, was well-managed and any areas for improvement readily identified.
- Further audits scheduled for 2019 included health and safety and infection prevention and control. These would be completed by the provider's health and safety manager.
- Audits included accidents, incidents, safeguarding, infection control, lone working, data management, both paper and electronic care records and personnel files.
- When people's paper records were returned to the office at the end of their care package, the registered manager audited the contents. They looked at compliance with adequate information documented, consent, accuracy of risk assessments, medicines records and the daily progress notes.
- The registered manager had found that insufficient details were recorded, and did not reflect the needs of the person. Some of the care details recorded used acronyms and technical language that would not be used by people and their family members.
- The registered manager and provider took steps to address the issues they identified with the quality of the documentation.
- The "person-centred rehabilitation plan" was redesigned to incorporate infection control, nutritional needs, skin integrity and the rationale for the rehabilitation support package. The service had moved away from a 'tick box' form to a holistic assessment process to ensure detailed information about people was recorded and reviewed.

- The changed form allowed more choice and control in the care package by people and their support networks.
- Since our last inspection, the registered manager created a matrix and distributed it to staff regarding their annual training. Staff also had a dedicated continuous professional development folder which linked the training requirements set out by the service with their own commitment to ensure they were knowledgeable and skilled.
- There was a business continuity plan in place which was detailed and included information about how to ensure provision of people's care during extreme circumstances. For example, there were plans in place for hot and cold weather and how to ensure people's support was provided during the royal weddings.
- The prior inspection ratings poster displayed in the office and on the provider's website.

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:

- People told us the service was well-led.
- The registered manager explained their responsibilities clearly. They said they were the, "...leader, an exemplar staff member, responsible for the service, and required to ensure people's safety."
- The registered manager felt that the management team were fair, supportive but firm when it came to the quality of the service. They said, "If there are quality errors or mistakes...then staff members are brought in to discuss any concerns, and how they can learn from this to prevent it happening again."
- The management team had increased their observation and self-reflection of the service. They had increased their knowledge of the day-to-day functions of the service so that they could ensure a continuous quality improvement journey.
- The head of regulated services explained their role was to ensure a clear development plan for the service. They were responsible for overseeing that the registered manager met their objectives, that the organisational structure was suitable and ensuring there was a cohesive team of staff employed.
- The provider employed a full-time quality lead who was responsible for understanding the requirements of the service and assisting with compliance tools and aids. They were an integral part of ensuring the governance arrangements between the service and the provider.
- The rearrangement of the provider's organisational structure was optimised and more flexible to the rapid changes within the adult social care sector. This meant changes could be made promptly to the operation of the service if new issues emerged.
- The accountability of the management team had increased since our last inspection, but the autonomy of the other staff was enhanced so that they could contribute to the safety and quality of the service. Staff felt empowered to take part in decision making and to speak up with managers.
- Short, 'stand up' meetings were held on Mondays, Wednesdays and Fridays between the different team members to examine service pressures and priorities. Where quick solutions could be identified to deal with any issues, these were put into place to ensure people received good care.
- The provider had a staff recognition scheme in place ('STAR' awards), and the registered manager and assistant manager had nominated three staff members.
- The registered manager had asked staff to complete a voluntary survey regarding workplace culture. They had received eight replies to a series of questions about the team feelings. The service had not measured the workplace culture before. The registered manager had analysed the findings and made conclusions from the feedback. They took actions to deal with areas where they could make improvements.

Engaging and involving people using the service, the public and staff:

- The assistant manager chaired the weekly care worker meeting. These meetings discussed people's changing needs, safeguarding, incidents and accidents and day-to-day care.
- Monthly, there was a staff meeting. The staff meeting included guest speakers that provided learning and educational opportunities. There were standing agenda items such as lessons learnt, policies and

procedures and any operational updates that staff need to know about.

- Staff surveys were sent out to employees during November 2018, but the results were not available at the time of our inspection.

Continuous learning and improving care

- Following our previous inspection, the registered manager liaised with the electronic care record provider to develop a 'dashboard' of incident and accident reports.
- The dashboard allowed the registered manager to have oversight of logged events on a monthly, quarterly and annual basis.
- The registered manager compared the paper-based incident reports with the information in the dashboard, to ensure that no information was lost in the process of logging the events. They were also able to produce reports which could be used for staff and management meetings, and reporting to the provider.
- The provider's quality lead provided information about changes made at the service since our last inspection. This included a "you said, we did" list of seven improvements. This detailed the issue we stated within our last inspection report, the action taken to address the matter and the outcomes for people who used the service.
- For instance, our prior inspection report stated, "Systems to ensure good governance of the service required improvement." The provider's noted improvement was, "A Head of Governance and Quality Assurance was recruited and remains in place, leading the team to provide accurate performance analysis and lean systems. [The registered manager] has regular contact with the Optalis Quality Lead and visits the service regularly, supporting the focus on continuous improvement."

Working in partnership with others

- The service had liaised with the local fire brigade to obtain a tool for referral of people at risk of fires in their home. The referral form was given to people and relatives so that they could contact the fire brigade directly, or the service coordinator could contact them on people's behalf. This allowed people at risk to have an assessment by a fire inspector and have smoke and carbon monoxide detectors installed free of charge. The fire brigade would also look at reducing the risks of a fire starting or mitigating harm if a fire had commenced.
- The service had created a "emergency hospital admission" form which could be completed by care workers in people's houses. This was filled in and provided to emergency services which ensured that both they and the hospital would have relevant information about people.
- For example, this included whether person had dementia, medical conditions, sensory impairments, allergies, whether there was a do not resuscitate order in place and list of medicines.