Derbyshire County Council

Cromwell House (DCC Homecare Service)

Inspection report

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

This inspection took place over 2, 3, 6, 8 and 13 November 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we wanted to visit the office, talk with staff and review records. Telephone calls to people were completed on 2, 3 and 8 November 2017. Telephone calls to staff were made on 13 November 2017. We visited the office on 6 November 2017.

At our previous inspection in July 2016, we found one breach of regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. We asked the provider to complete an action plan to show what they would do and by when to improve the key question, 'How are people's medicines managed so they receive them safely.' At this inspection we found improvements had been made.

This service is a domiciliary care agency. It provides personal care to people living in their own homes in the community. It provides a service to older adults and younger disabled adults, in and around the high peak area of Derbyshire. Not everyone using Cromwell House (DCC Homecare Service) receives regulated activity; CQC only inspects the service being received by people provided with 'personal care'; help with tasks related to personal hygiene and eating. Where they do we also take into account any wider social care provided. The provider informed us 99 people received support with their personal care needs.

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 there was a registered manager in post.

People were kept safe and the risk of abuse was minimised because the provider had systems in place to recognise and respond to allegations or incidents. Other risks were assessed and actions taken to reduce known risks. Pre-employment checks were completed on staff to check their suitability for the role. Sufficient numbers of staff were available to care for people and further recruitment was planned to keep staffing levels sustainable. Medicines were managed safely and practices were in place to prevent and control any infections.

People made decisions in relation to their care and support; where they needed support to make decisions

their rights were protected under the Mental Capacity Act 2005. People understood their care and support because they received information in a format that met their needs.

Staff received training in areas relevant to people's needs and received support through supervision meetings. People's health and any associated risks were monitored and responded to; referrals to other healthcare services were made where this would be of benefit. Where staff provided care with people's meals, this was done in a way to help people maintain a balanced diet.

People were cared for by care staff who were kind and caring. Care staff respected people's privacy and dignity. People were supported with their independence by staff who understood how important this was for people's wellbeing.

People were involved in decisions, as well in the planning of their care and support. Staff were aware of people's interests, hobbies and preferences. Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans with them. This helped to ensure people did not experience any discrimination.

People knew how to raise issues and where they had done so these had been investigated and people had received a response.

A registered manager was in place and they understood their responsibilities for the management and governance of the service. Systems were in place to monitor and improve the quality of the service provided. The service was focussed of achieving good quality outcomes for people. The service was managed with an open and transparent culture where people were listened to and staff were valued.

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.

Risks were assessed and actions take to reduce incidents. Medicines were well managed and actions were taken to prevent and control infections. Sufficient staff were available to meet people's needs. Staff recruitment included checks on the suitability of staff to work at the service. Staff understood how safeguarding procedures helped to protect people.

Is the service effective?

Good

The service was effective.

People's needs and choices were assessed in a way that helped to prevent discrimination and people's decision making was taken in line with the MCA.

People had access to information in a format which met their needs and staff received appropriate training and supervision. People's health was monitored and responded to appropriately.

Where people received care with their food and drink, this helped people maintain a balanced diet. Consideration had been given to where adaption of people's homes may benefit them.

Is the service caring?

Good

The service was caring.

People were cared for by care staff who were kind and who respected their privacy and dignity and promoted their independence.

People were involved in decisions about their care and support.

Is the service responsive?

Good

The service was responsive.

People were involved in planning their care and support. Staff

were aware of people's interests, hobbies and preferences.

People were supported to raise issues and these investigated and people received a response.

Is the service well-led?

Good

The service was well led.

A registered manager was in place and they understood their responsibilities for the management and governance of the service. The service was focussed of achieving good quality outcomes for people.

There was an open and transparent culture in the service where people were listened to and staff were valued.

Systems were in place to monitor and improve the quality of the service provided.

Cromwell House (DCC Homecare Service)

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection checked 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 between 2 and 13 November and was announced.

We gave the service 48 hours' notice of the inspection visit because we asked registered manager to make arrangements for us to be able to call people. We also wanted to visit the office, talk with staff and review records.

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 and younger disabled adults.

The inspection team included one inspector and an expert by experience. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service. Their area of expertise was in the care of older people.

Before the inspection we looked at all of the key information we held about the service, this included whether any statutory notifications had been submitted. Notifications are changes, events or incidents that providers must tell us about; no notifications had been submitted. The inspection was also informed by feedback from questionnaires completed by a number of people using services, their relatives, staff and community professionals who had experience of working with the service.

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.

We also checked what information Healthwatch Derbyshire had received on the service. Healthwatch Derbyshire is an independent organisation that represents people using health and social care services.

In addition, during our inspection we spoke with eleven people who used the service and eight relatives of people who used the service on the telephone. We also spoke with the registered manager, two domiciliary care organisers who had responsibility for organising peoples care and three care assistants.

We looked at three people's care plans and reviewed other records relating to the care people received and how the agency was managed. This included risk assessments, quality assurance checks, staff training and recruitment records.

Good

Our findings

At our previous inspection we found a breach of Regulation 12 of the Health and Social Care Act (Regulated Activities) Regulations 2014. This was because care and treatment was not always being provided in a safe way as arrangements for the proper and safe management of medicines were not always in place. The provider submitted an action plan that told us what actions they planned to take to make improvements. At this inspection we found improvements had been made.

People told us staff took steps to make sure they administered their medicines safely. For example, one person told us, "I feel very safe with them. I like it when they check I have taken my tablets in case I forget to, and that makes me feel comfortable and safe." Another person told us, "[Care staff] always wear gloves when giving me my tablets which they take out of a blister pack and they put them in an egg cup with a glass of water; they then watch me as I take them." People and relatives told us care staff updated their medicines administration record [MAR] charts when any care have been offered or provided with medicines. One relative said, "[Care staff] always complete a MAR sheet after they have finished [my family member's] care."

Care staff we spoke with were knowledgeable about the levels of support people required with their medicines. For example staff knew when people could safely manage their own medicines and when they required assistance from care staff. One care staff also told us how they worked with other healthcare professionals to ensure medicines were managed safely. They said, "We don't give medicines unless we have a MAR chart in place; one person needed anti-biotics, they were very important and so we went to an out of hours pharmacist to get a MAR chart in place." These actions help to ensure people received their medicines as prescribed and staff were aware to follow processes designed to manage people's medicines safely.

Records confirmed people had care plans and risk assessments in place and these enabled staff to understand what care was required. For example, records showed the steps staff took to assess that a person could safely manage their own medicines. One person told us, "I do my own medicines." In addition, we saw MAR charts were completed by care staff when they had administered any prescribed medicines, including creams to people. Care staff told us they would check MAR charts on each visit and report to the office if they identified records had not been completed as required so this could be investigated. MAR charts were retuned on a regular basis to the office or further checks to ensure people received their medicines as required. The provider had policies and procedures in place that were discussed with, and followed by care staff who had been trained in medicines administration and management. In addition, regular checks on records helped to ensure the proper and safe use of medicines was in place. These actions

helped to ensure people received safe care around the management and administration of their medicines.

People told us they felt staff took steps to help prevent and control infections. One person told us, "They definitely wear gloves and aprons when seeing to my personal care." A relative told us, "What I like is that they always wash their hands first before they start to do anything." Staff we spoke with told us they had adequate supplies of gloves and aprons and had been trained in prevention and control of infections. Where staff were involved in the preparation of food, records showed they had also completed training and awareness in food hygiene practices. The provider had taken steps to ensure people were protected by the prevention and control of infection.

People told us they felt free from any discrimination with the service provided by Cromwell House (DCC homecare). One person told us, "I have never had any discrimination." Another person told us they were treated, "Very fairly; discrimination? No never." Whilst a relative added, "[Care staff] are all very fair and caring throughout; there's certainly no discrimination issues."

People also told us they felt safe with the care provided, for a variety of reasons. One person told us, "I do feel safe, yes. I have elasticated stockings that I can't do myself and they carefully help me on and off with them. They support me safely on my shower days so I don't fall and they lock me up safely at night when they go." One relative told us they felt the service provided safe care. They said, "I feel quite safe with them all; they wash and shower [my family member] very gently and carefully and secure the property after they have finished; they leave everything clean and tidy." People's safety was supported as staff provided safe care and ensured other risks to people's safety, such as the security of their homes was attended to.

Staff we spoke with were knowledgeable of the types of abuse harm that people may sometimes be at risk from and some of the signs that could indicate a person may be being abused. For example staff told us they would report any unexplained bruising, or if a person's behaviour had changes and if they appeared worried or frightened. Staff told us they had regular training in awareness of abuse and the steps to take to ensure people were safe. The registered manager told us there had not been any safeguarding incidents since our last inspection; however they told us processes were in place to manage and respond to any concerns should they occur. Another member of staff told us, and records showed where staff had worked with the local safeguarding team when people had transitioned into other care settings to ensure their continued safety was supported by appropriate sharing of information. The provider had systems and processes in place, and staff were knowledgeable of and followed processes deigned to ensure people were safe.

People told us they felt staff provided care safely and took action to reduce any associated risks. For example, one person told us, "As I suffer with balance problems [care staff] always make sure there is nothing lying about that may make me topple over." Another person told us, "I have a rail by my bed to get me up and a trolley with armrests and a wheelchair and reclining chair. [Care staff] always make sure it is safe for me to get around when they are here and if anything is lying on the floor they will pick it up." The service worked with people so that they understood how staff helped them reduce any risks associated with their care.

Staff who arranged people's care told us they checked to ensure all risks, and actions to reduce risks were identified before a person started to receive care from the service. For example, one staff member told us before a person received care they would read all the assessments completed by the social worker and occupational therapist and identify any risks. They said if a person had been assessed as being at a high risk of falls, they would complete a falls risk assessment and consider whether any referrals were needed to the community rehabilitation team. Records confirmed that risk assessments were in place for such areas as falls prevention and other areas of risk, such as medicines management and skin care where there was a risk

of pressure area damage. Care plans were up to date and identified what steps care staff should take to reduce any associated health risks. For example, one person who had a weakness on one side of their body. The care plan asked staff to prompt the person to lift their weaker foot from the ground when walking to minimise the risks of them falling. Risks to people were assessed and their safety monitored and managed in a way that promoted their freedom and independence.

People told us they did not routinely experience any missed calls and told us care staff were usually on time. One person told us where a call had been missed they had contacted the office and received an apology. Office staff confirmed any reports of missed or late calls were investigated to ensure any improvements could be made. One person said, "[Care staff] are usually on time and do phone if they are going to be late; they always stay their time." Another person told us, "Timing is good; they have never been very late and never missed coming to me and always stay the full time." A relative added, "I know they are mostly on time as they clock in and out when they go to [my family member] and I check on my phone bill which confirms their times are good and they stay the allocated time with them." Sufficient numbers of staff were available to provide people's care.

People told us enough staff were available to provide them with safe care. One person told us, "I always get my full time with [care staff]." Relatives told us where two care staff were needed to provide safe care to their family members, this was provided. For example one relative told us, "[My family member] has a double up call in the morning and evening and a single carer for lunch and tea time. They have never let them down by only one [care staff] coming and they need the two of them to move them in and out of bed."

We discussed with the registered manager and staff with responsibility for organising care calls how they planned and managed staff. They told us they would not take on a care call unless they had staff available. They also told us staff worked, where possible in geographical areas and this helped make effective use of staff time. They also aimed to match new staff alongside more experienced staff when they first started. Staff we spoke with confirmed they had the opportunity to work alongside more experienced staff when they started. Another care staff told us when they identified changes to a person's needs and they required a longer care call, they had discussed this with the office who had arranged for an assessment. They told us this had resulted in a longer call time for the person. Care staff we spoke with also told us they would discuss their rotas with the office if they could identify more effective routes to enable people's care to be provided on time. Staffing was planned safely and took account how many staff were needed as well as any differences in their skills and experience.

Not all people we spoke with received a call when care staff were running late and they told us they would appreciate a call. For example one person told us, "Times are mostly okay, but they don't phone me if they are held up; would be nice if they would; they should tell me. They always turn up though and stay the time." A couple of other people raised questions with us about their calls times, or the consistency of staff. We discussed these with the registered manager so they could review people's comments and respond appropriately.

Staff told us, and records confirmed any accidents, incidents and near misses were reported. Discussions with people and staff were held when needed to establish any causes of the incident. Records showed improvements had been identified when a person had a near miss when staff assisted them to move with a piece of equipment. Records showed improvements had included a change to a different piece of equipment so that risks to this person when using it were reduced. Actions were taken to improve safety.

Staff meeting minutes showed steps were taken to prevent accidents, incidents and near misses. Health and safety issues were regularly discussed and checks were made to ensure staff had appropriate equipment to

help them work safely. For example, checks were made to ensure staff had personal safety alarms, torches and first aid kits. Staff discussed areas of risk in their work and the steps they should take to work safely and prevent incidents from occurring. Records showed staff discussed changes to a person's care plan when an incident had occurred. This enabled staff to have a clear understanding of what action to take and the reasons for the change. The service identified when things went wrong and used learning from these incidents to implement further improvements.

Good

Our findings

People told us they felt confident in staffs' skills, knowledge and experience to provide the care they needed. One person told us, "I would say they are well trained and that shows in them knowing and remembering what I like and don't like." Another person told us, "Yes their skills are good; they soon sort me out if am doing something wrong like not putting my cream on right." A relative told us, "[Care staff] skills and training come through as being very good. It is a brilliant service that they give." Staff told us they felt the training they had prepared them for their job role. One care staff told us, "I feel supported; they are really good for training and I've done extra shadowing [with another member of staff] until I have felt confident." Another care staff told us, "I'm doing some more training tomorrow." Records showed staff were trained in areas relevant to their job role. For example, care staff who worked in the 'reablement' service had all been trained in how to promote people's independence. The service had provided staff with the skills, knowledge and experience they needed to deliver effective care and support.

People received care and support with their meals and drinks. One person told us, "[Care staff] know what I fancy, especially around food when they will fry me egg and bacon." Another person told us, "[Care staff] prepare me a microwave meal and for breakfast get me cereal or porridge, depending on what I feel like having." One relative told us how staff understood their family member's requirements for specialised food associated with their health condition. They said, "[My family member] now has a soft food diet and [care staff] are aware of this; they give them a nutritional shot every morning as a drink. Also [care staff] saw they were not drinking out of cups so they now leave a thermos cup and they are quite happy drinking out of that."

Staff we spoke with were knowledgeable about people's nutritional and hydration needs. For example one care staff told us about a person whose drinks required thickening, how they did this and what consistency was required. They told us the person's care plan included this detail and included the assessments that had been completed to identify the care the person required around their fluid intake. Records confirmed people's needs around their diet and fluid intake were assessed. For example, one person's care plan identified staff needed to prompt one person living with dementia to eat and drink regularly. Records also showed that where a person was diabetic, care staff had used sweeteners in drinks rather than sugar. Where staff provided care with people's meals and drinks they ensured people received a balanced and nutritious diet.

Staff with responsibility for organising people's calls told us they worked with other organisations and other professionals to ensure people received effective care. For example, staff told us when they would make

referrals to occupational therapists when people needed and assessment for them to mobilise; or referrals to speech and language therapists if a person was experiencing difficulties swallowing. Records showed where arrangements had been made for one person to access the bathing facilities at a local daycentre as they were able to use the bath lift there with staff support. Another time records showed where staff had sat with the person when an engineer came to work on their gas supply. Care plans and records included any advice and guidance given by other professionals for staff to follow. Staff we spoke with were knowledgeable on how to work with other organisations involved in people's care. For example, one staff member told us how they worked with the local pharmacy to ensure MAR charts were in place when a person had been prescribed some additional medicine. People were helped to receive effective care because staff and the service worked with other organisations involved in meeting people's care.
People were supported to maintain their health and access ongoing healthcare support. One person told us, "[Care staff] display a lot of knowledge and when I wasn't well they knew what was wrong and contacted my doctor and the nurse for me." Another person said, "[Care staff] have phoned my doctor twice now when they have called and found me unwell." Another person told us, "I had a fall once and [care staff] called the ambulance and waited until it came." Daily records showed where staff had escorted a person to a hospital appointment. Staff we spoke with told us they were aware when people were not feeling well. One staff member told us they would always offer to call the person's doctor, and always let their family members know if they seemed unwell. One care staff told us, "We care for the same people; we see them on a day to day basis and we get to know when they are upset or not well." People were supported with their health as care staff knew how other healthcare services could benefit people.

Assessment of people's diverse needs, including in relation to protected characteristics under the Equality Act were considered in people's care plans with them. This helped to ensure people did not experience any discrimination. Other assessments of people's needs were completed in line with current legislation, for example decision making was taken in line with the MCA. Where people required specific assessments associated with their health conditions we saw referrals had been made so the assessment could be made by the appropriate professionals and in line with their professional standards. For example, we saw people had been assessed by speech and language therapists when they experienced changes to their ability to swallow. Assessment processes were in line with current legislation and standards and helped to achieve effective outcomes for people.

People we spoke with told us staff would always check they consented to receive care before this was provided. One person told us, "[Care staff] always ask how I am and don't start anything without asking me if it is okay first." Staff we spoke with understood the importance of only providing care to people with their consent.

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. The service had policies in place that covered the MCA and making decisions in a person's best interests. When people lacked the mental capacity to make some specific decisions by themselves, staff with responsibility for organising people's care had attended meetings with other professionals, family members. Where appropriate the service had made referrals to advocacy services and involved them in any meetings regarding people's decisions. These meetings were to discuss what decisions were considered to be in a person's best interests.

People's consent to their care and treatment was sought by staff in line with the MCA.

Good

Our findings

One person told us they thought staff had a very caring approach. They said, "We have a laugh together and they are all gentle when changing my tight stockings, ensuring I am comfortable and not hurt in any way." Another person told us, "[Care staff] are like friends; I call them 'caring carers'." Relatives we spoke with shared this view. One relative added, "It's a brilliant service, the carers know [my family member] well and, yes, very caring with what they do for him."

People told us they felt staff did extra things that conveyed they cared, including provided emotional support and reassurance when this was needed. One person told us, "[Care staff] certainly are caring; they will not leave me if [I'm] not finished so that shows they care in my book." A relative told us one morning they had been busy and had not had time to make their family member's bed. They said, "When I returned, the care staff had put the duvet back on and made it all for me; I was chuffed; it's the little things like that they pick up on that makes me feel good about them." Another relative told us, "[Care staff] sit and talk and do things with [my family member] like reading books and watching television." Staff we spoke with were mindful of how people were feeling. One care staff told us they would report to the office if they were worried about a person and would always offered to see if they wanted to see a GP or anyone. Records showed staff were aware of people's mood and did contact family members and other professionals when appropriate. The service took action to ensure people were treated with kindness, respect and compassion and given emotional support when needed.

People told us care staff respected their privacy and promoted their independence and dignity. When we asked one person they told us, "Very much so; I have a balance problem but care staff encourage me to try to get around safely on my own and do things around the house for myself." Another person told us, "[Care staff] make sure that I am partially covered when creaming me which is respectful and encourage me to do things for myself where I am able to." Some people had also been supported by the 'reablement' service. This service provided responsive levels of support for a period of approximately six weeks. This enabled people to increase their levels of independence, when for example, a person was recovering from a stroke or an operation. One person told us, "[Care staff] always hand me a towel and look the other way when I am drying; they help me about the house as I am recuperating after hospital treatment. The also make sure things are close to hand to make my life easier until I am back fully mobile."

Staff we spoke with had a good understanding of how to promote people's independence. For example, staff knew what people were able to do themselves and what they required help with.
Records confirmed people's independence was promoted and how this had positive outcomes for them. For

example, one person's care plan stated, 'reassure me and involve me in day to day activities as this keeps me going.' People received care from staff who understood how to promote people's independence with provide care with dignity and respect.

People were involved in decisions about their care and what support they required. One person told us, "[Care staff] are all nice and polite and check my care plan and speak to me before commencing on anything." Another person told us, "My care plan is in my folder and they ask me questions about it and I have input into anything back to them." Relativities we spoke with also shared the view, people's care plans reflected their views and they were able to make decisions regarding their care. For example, on relative told us they were involved and helped share their family member's views. Staff told us, and records confirmed care plans were discussed with people and their views and preferences for care were recorded. For example, one person's care plan reflected that they wanted to put their hearing aids in themselves, but would sometimes need the assistance of staff to help with the battery. Care plans were discussed with people; this meant people had access to information that enabled them to understand their care needs and the health services available to them and this ensured people were not unduly discriminated against.

Good

Our findings

People and families felt the care provided was personalised and responsive. One person told us, "[Care staff] move me in my chair and I like watching television and they make sure I have the remote control close to me so I can swap channels." A relative told us about their family member who was cared for in bed. They said, "[Care staff] have encouraged them to use a [computer tablet] and they like to play peek-a-boo with [care staff] under the bed sheets; [care staff] readily engage with them doing this." Staff told us about some of the different and inventive ways they worked to help provide personalised and responsive care. One staff member told us about a person they cared for who was recovering from a stroke and building up the strength in one side of their body. The staff member told us, "I had arrived a little bit early and was sitting having a natter about where they used to live; I suggested they have a go at writing again as I had seen them do this before; they seemed to enjoy it."

Care plans showed where care and support was centred on people's needs, and had involved people's views and where appropriate those of their family members. For example, one person's care plan reflected they needed a drinks flask prepared for the evening as they struggled to see clearly enough to make hot drinks safely. This person's care plan also recorded their interest in history and how they liked to show people memorabilia from that era. In addition we saw people had been asked for, and had recorded their ethnicity, their first language and any communication needs. This was so any associated needs could be identified and how best to meet those needs could be discussed with people. Staff told us they were aware some people requested earlier calls on a Sunday so as to be able to attend their place of worship. Staff also discussed how they communicated with people who had additional communication needs. For example, one staff member told us a person would ask them to read any letters that arrived to them as they were visually impaired. For another person, staff told us they helped the person use know objects to help the person indicate their choices. The service provided care that met with the accessible information standard.

People told us the use of technology had been discussed with them where staff felt it may help with their care. For example one person told us, "Yes, [care staff] have mentioned about fall sensors." One relative told us their family member benefitted from a chair that could be controlled electronically. Another relative told us, "Yes, [care staff] have actually mentioned technology but we haven't pursued anything as yet." People were supported to receive personalised and responsive care to meet their needs. This was because the service involved people in discussions about their care. Any needs associated with their health and wellbeing were identified and met through a variety of ways; these included an understanding of a person's culture and faith, their interests, preferences and how the use of technology may assist people.

Some people we spoke with told us they were in the process of discussing the timings of calls, or the consistency of the care staff with the office. They told us they felt confident to discuss any issues with the office staff and felt these discussions had in the past lead to improvements for them. One person told us, "I had a poor carer [once] but they stopped them coming; I just phoned them and they sorted it out." Most people we spoke with told us they had not had to make a complaint, but felt confident to do so if this should be required. One relative told us, "No complaints at all, we could not do without the service; we have the procedure here if it was ever required." Information on how to make a complaint had been provided to people in the form of an information leaflet. We saw one of these had been filled in and returned to the office. The registered manager had investigated their complaint and had found, on this occasion the service had not meet the standards expected. The registered manager sent a written apology with their findings and informed he person they would continue to monitor the provision of their care. Information on how to make complaints was accessible to people and complaints were formally recorded, handled in a transparent manner and used to inform improvements to the service.

Good

Our findings

People told us they felt the service was well-led and provided high quality care. One person told us, "The carers' skills are good and I am very happy with the service provided." Another person told us, "I think it is certainly well managed and led with very pleasant carers." A relative added, "Well put it this way, I would definitely not look to go anywhere else for their care." We found staff were trained in areas consistent with the aims of the service. For example, promotion of people's independence was included as an aim in the provider's Statement of Purpose. A Statement of Purpose sets out clearly what the service intends to do and how. The service helped to deliver this aim by providing a 'reablement' team, where staff were trained specifically in 'reablement' skills to promote people's independence. The service was focussed on achieving good outcomes for people and promoted a person centred culture that promoted people's independence.

Staff we spoke with were enthusiastic and committed to providing high quality care. The registered manager told us they worked to promote good team working amongst the staff teams. Regular staff meetings and staff supervision meetings were used to review staff attitudes and values as well as check with staff they felt positive in their job role. Supervision provided staff members with the opportunity to reflect and learn from their practice, receive personal support and professional development. Staff told us they received reminders about good practice from their managers. Records confirmed reminders about completing MAR charts correctly had been issued and discussed at staff meetings. In discussions with the registered manger they told us they aimed to work in an open and transparent way. They told us, "Staff can bring any issue and we problem solve it there and then." Staff told us they found the registered manager and the staff that organised care calls supportive. One staff member told us, "I can write, email or phone them and they will get back to me straight away." The registered manager had taken steps to ensure staff were supported, treated fairly and worked in an open and transparent culture.

There was a registered manager in post at the service. 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 understood when notifications were required. Notifications are changes, events or incidents that providers must tell us about.

The registered manager had systems and processes designed to assess, monitor, improve services and identify and mitigate risks. Audits had been completed in such areas as health and safety and on infection prevention and control practices. Further checks had been completed to identify any staff who required

specific equipment for their job role, such as first aid kits and equipment that reduced risks of electrical shock when using electrical equipment in people's homes. Governance arrangements made sure staff and managers were clear on their roles and responsibilities for managing risks and meeting regulatory requirements.

People told us they had opportunities to feel engaged and involved with how the service was provided. For example, people told us they had contributed to their care plans, raised feedback and complaints and these had been responded to. In addition some people and their relatives had received specific feedback requests from the service to ask them about the quality of care. For example one relative told us, "Yes, we do get feedback requests from them." The registered manager had analysed the responses to a questionnaire sent out in May 2017. We saw the responses to questions asked about the quality and safety of services were positive. Where people had stated they were not happy about an aspect of their care, we saw office staff had visited people to discuss with them and resolve any concerns, or provided them with further information. For example, when people stated they were unclear on how to make a complaint we saw office staff had responded by sending out information on the provider's complaints process.
In addition minutes of team meetings showed staff were asked for their ideas by the registered manager on what improvements could be made to the service. Steps had been taken so that people and staff engaged with and were involved in improving the service.

The registered manager told us they wanted to be able to continuously improve the service. For example they told us they, "Wanted to set the tone for staff to come in and talk about [any issues]." They told us they had talked with staff who had left the service to understand why they were leaving and if there was any learning or improvements that could be identified from staffs' experiences. Recruitment of staff was planned to ensure and support the sustainability of the service.

People told us, and records confirmed where other professionals had been involved in their care and treatment. Relationships had been developed with local pharmacies as well as local health services. Where people required a referral, for example for an assessment on how best to mobilise and what equipment would be most suitable, these had been made. Any information provided by other agencies had been used to inform and develop people's plans of care to ensure good outcomes for them. For example, we saw where a person had been assessed by an occupational therapist, a report of their recommendations had been used by the service to inform the person's care plan. The service worked in partnership with other agencies.