

HISC Wigan Limited

Home Instead Senior Care Wigan

Inspection report

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Ratings

Overall rating for this service	Good ●
Is the service safe?	Good ●
Is the service effective?	Good ●
Is the service caring?	Good ●
Is the service responsive?	Good ●
Is the service well-led?	Good ●

Summary of findings

Overall summary

This inspection took place on 24 July 2017 and was announced. The provider was given 48 hours' notice of the inspection because they provide domiciliary care and we needed to be sure someone would be in the office to facilitate the inspection. This was the first inspection undertaken at the service since registering with the Care Quality Commission (CQC) on 28 July 2015.

The service provides care to people in their own homes. At the time of the inspection 28 people were receiving support of which seven people received personal care. We only looked at the service for people receiving personal care as this is the regulated activity that is registered with the Care Quality Commission (CQC).

At the time of our inspection, there was no registered manager in post. The service had a manager that had commenced in post 10 July 2017. They had commenced the process of applying to the Care Quality Commission (CQC) to register and their application was in progress. 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.

For the purpose of this report we have referred to care staff as caregivers in line with the services terminology when referring to care staff.

We found people's care files were comprehensive, well organised and easy to follow. Risks to people's health, wellbeing and safety had been assessed and plans formulated to mitigate identified risks.

The management of medicines promoted people's safety. There was a detailed medicines policy and procedure in place that had been recently updated in line with best practice.

The service had a robust recruitment process to help ensure caregivers employed were suitable to work with vulnerable people.

There were sufficient numbers of caregivers deployed to ensure people's needs were met. Care and support was designed around the person and caregivers were recruited based on people's needs. Caregivers were matched to the person they supported to promote positive relationships to develop.

Caregivers understood the Mental Capacity Act 2005 (MCA) and considered this when supporting people who lacked capacity to make certain decisions. People's power of attorney (POA's) were clearly identified in people's care files so staff had access to the required information.

Caregivers were passionate about the care they provided and spoke fondly of the people they supported.

Support plans were person centred and caregivers had a comprehensive knowledge of people and their needs which demonstrated a commitment to people receiving person centred care. People were encouraged and supported to pursue their individual hobbies and interests and caregivers actively sought opportunities to promote people's independence.

Management demonstrated a commitment to caregivers to continue their professional development to maintain skills and deliver best practice. Caregivers were supported through induction, supervision and training to promote better outcomes for people.

People who used the service were fully involved with decisions about their care and we were told they were given choices in relation to their care delivery and their personal preferences were taken into account.

There was a complaints policy in place and although at the time of the inspection there had not been any complaints received, there were systems in place to track complaints.

Feedback was sought from people, relatives and caregivers through surveys and quality assurance systems.

Leadership was strong and management demonstrated a clear vision of what was required to provide a quality service. The service worked in partnership with other agencies and people were signposted to community services to promote better outcomes for people receiving support.

Audit systems were effective and in place to monitor the quality of the service delivered.

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

The service had safeguarding and whistleblowing policies and procedures which staff demonstrated they knew in order to keep people safe.

Risk assessments were comprehensive and reviewed regularly. Care plans detailed measures to mitigate risks and were easy to follow.

Processes were in place to ensure people's medicines were managed safely.

Is the service effective?

Good ●

The service was effective

Staff received an induction and comprehensive training to support them to undertake their role.

People had provided consent to their care, with decisions made in their best interest by their next of kin or legal representative.

People's choices were respected and staff understood the requirements of the Mental Capacity Act 2005.

Is the service caring?

Good ●

The service was caring

People were supported by a familiar staff team that knew their needs.

People's dignity was maintained and their independence promoted.

People were complimentary about the care received.

Is the service responsive?

Good ●

People's support, risks and care needs were identified, assessed and documented within their care plan.

People's needs were reviewed on a regular basis.

People were aware of the complaints procedure and given information on how to make a complaint at the commencement of the service.

Is the service well-led?

The service was well-led

There were effective processes in place to monitor the quality of the service.

The provider worked to establish community links to support better outcomes for people.

The provider ensured statutory notifications had been completed and sent to CQC in accordance with legal requirements.

Good ●

Home Instead Senior Care Wigan

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.

The inspection took place on 24 July 2017 and was announced. The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure the manager would be available to facilitate the inspection.

At the time of our inspection there were 28 people receiving support from the service, with seven people receiving a regulated service which was personal care.

The inspection team consisted of one adult social care inspector from the Care Quality Commission.

Before the inspection, the provider completed a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We also spoke to the local quality monitoring team whom provided positive feedback regarding the service.

During our inspection we went to the office and spoke with the business manager, quality assurance manager, manager and two caregivers. We also received email feedback from a further two caregivers and sought feedback by telephone regarding the quality of the service from three people and relatives that were in receipt of personal care support.

During the inspection, we looked at various documentation including four care files for the people receiving a regulated service and five staff personnel files. We looked at staff recruitment information, supervision

notes, training, staff rota's, visit schedules, policies and procedures and three medication administration records (MAR).

Is the service safe?

Our findings

We asked people and their relatives if they had any safety concerns whilst receiving support from the service. A person told us; "No safety concerns as such but some carers are more competent with things than others." A relative said; "They did miss a couple of night visits but nobody was harmed and it has got better. I've no safety concerns."

Caregivers demonstrated a good understanding of people's needs and demonstrated how they maintained people's safety whilst promoting their freedom. A care giver told us; "[Person] isn't safe near roads so we take walks around the park or golf courses. It means they get out and I don't feel I need to be? right on them all the time."

We looked at recruitment and found it was person centred and based around what people wanted from caregivers. The provider had templates in place which were given to caregivers and the person receiving support. Caregivers and people were matched taking in to account their personalities, availability and the area the person lived. All caregivers employed had been through a thorough recruitment process before they started work for the service. We looked at five staff personnel files and saw they contained an application form detailing work history, interview questions and two references. Disclosure and Barring checks were in place to establish if there had been any cautions or convictions, which would exclude them from working with vulnerable people.

We looked at how the service ensured there were sufficient numbers of caregivers to meet people's needs and keep them safe. A caregiver told us; "I have a set number of people that I support. It is the same for everybody. I only support a small number of people so no concerns regarding staffing. We have sufficient time with people to meet their needs."

The management had introduced electronic software which took in to account people's needs and caregivers travel time. Caregivers had an IQ time card and were required to log in to the system when they arrived at the person's home to provide care. This enabled management to monitor that caregivers had arrived and were with people at the identified time. We asked people and their relatives if there had been missed visits and whether caregivers were with them at the required time. Comments included; "They're generally at the right time. There have been couple of occasions when I've rung the office and cancelled the visit and caregivers have still come as they haven't received the message. That is a rarity rather than the norm though."; "They're about the right time. I have had problems with the double up visits but I have to say things have got a lot better."

We looked at the systems in place to safeguard people from abuse and improper treatment. We saw there was an up to date safeguarding policy in place which had been revisited at team meetings to maintain staff knowledge. Emergency contacts at the local authority had been shared with caregivers so they had the required information to report any concerns timely. We asked caregivers about their understanding of safeguarding, whistleblowing and how they would report any concerns. All the staff we spoke with confirmed they had received training and were aware of the local tier system and safeguarding procedures.

Caregivers told us; "Ensure client is safe. Notice if anything happening that is not ethical or in best interest of client. Abuse could be not maintaining client's self-care. I'd tell the manager straight away."; "I've raised safeguarding concerns. Vulnerable people being exploited and paying thousands for a few hours work. Other issues could be if a person had bruises or their care needs not being met. I'd document observations and report straight to the office. I'd whistleblow to CQC if things weren't addressed."; "Safeguarding is to assure everyone, especially vulnerable adults are safe and free from risks, abuse, fear, neglect and anything that will affect their health, safety and wellbeing. I report my concerns immediately to the office, seek advice and document it in activity log book."

We looked to see how staff managed people's medicines. We saw that arrangements were in place to ensure people received their medicines safely and as prescribed. We were shown the updated medicines policy and procedure which had been reviewed in line with guidance and best practice recommendations.

The caregivers confirmed they had received medicine management training before providing medicines support to people. We also saw competency assessments were undertaken before staff began administering medicines without supervision.

Information in people's support plans showed the level of support people required for the administration of their medicines, who was responsible for ordering, when, from which pharmacy and where their medicines were stored within the home. The care plans we looked at contained the person's medication administration record, a record of where and when topical (skin) creams were to be applied and information was available in each person's support plan to guide staff when they had to administer medicines that had been prescribed as 'when required'.

We saw covert medicines plan in place for one person which had been agreed with the person's GP and discussed with pharmacy to ensure the prescribed medicines would still be effective if given with food.

We found people had various risk assessments in place that were completed in line with people's identified needs. There were clear plans to mitigate risks that were organised and easy to follow to keep people safe within their own home. There were also assessments undertaken around the general safety of people's homes. Taking in to account things such as lighting, security and electrical and fire safety. Any risks or hazards were identified and photographs had been taken and a risk plan put in place. For example; if rugs or bath mats were considered a trip hazard then control measures were identified. Practical information was also recorded regarding safety cut off points for the water.

When people had accidents, incidents or near misses these were recorded, with details including a brief description of what had occurred, the action taken and the outcome. The management reviewed and analysed these records to look for developing trends and resulting actions were discussed with caregivers at team meetings to ensure people received their on-going care and support in a safe way.

Is the service effective?

Our findings

We asked people and their relatives if they felt the staff were well trained and had the required knowledge and skills to provide effective care. Comments included; "They seem well trained. It's all settled down and we have two regular carers that I have to say are really very good." "They seem well trained. Some need telling sometimes but on the whole they are good."

The induction consisted of staff completing the care certificate. The care certificate assesses the fundamental skills, knowledge and behaviours that are required to provide safe, effective and compassionate care. It is awarded to care staff when they demonstrate that they meet the 15 care certificate standards which include; caring with privacy and dignity, awareness of mental health, safeguarding, communication and infection control.

We looked at the training and professional development caregivers received to ensure they were fully supported and qualified to undertake their roles. The electronic training system in place was called grey matters and there was additional face to face training undertaken in conjunction with this. Training was provided in MCA/DoLS, safeguarding, medicines, manual handling, food hygiene and first aid. One caregiver said; "There is enough training to support us in role. Nothing is taken to chance." Another care giver said "I have done mandatory training such as CPR, manual handling, adult safeguarding, Grey Matter and I have recently enrolled in distance training for End of Life Care (EoL)."

Some of the caregivers had become dementia friends and 15 caregivers had participated in a living with dementia experience day. The aim of the day was to provide caregivers the experience of being in someone else's shoes. They were given an experience of how it is to function with different things going on around them using distraction techniques to confuse them and then being asked to remember information and recalling items following a pathway. Challenges included; trying to tie shoe laces with two fingers fastened together and fastening a shirt with goggles on.

Staff received supervision in line with the provider policy. Supervision was provided every six months and caregivers had an annual appraisal in addition each year. Spot checks were also conducted regularly to assess caregiver's performance. Caregiver's told us; "We have regular supervision. At least two a year and an annual appraisal. If I wanted more supervision, somebody to speak to if needed to." The feedback is good and reinforces what I'm doing is right. Mistakes are reflected and if not detrimental- move forward."

We saw there were effective communication systems in place. Caregivers completed daily logs following their support in order to provide a handover to each other. The management also communicated actions and issues from the on call and discussed what had occurred the previous day and outlined what was happening the current day.

We looked at how the provider obtained consent for any care and support provided. We saw people or their representatives had signed a contract agreeing to the care and support they would receive. Whether people had a power of attorney (POA) in place was clearly identified in people's care files.

People, their relatives and caregivers also confirmed consent was obtained prior to undertaking care tasks, Comments included; "They always ask [person] first before doing things."; "Yes, they always ask me. They say would you mind if I do this or are you ready for that." "I've no concerns. There's a continued conversation and making sure things are okay is part of that."

We checked whether the service was working within the principles of the MCA. We found that documentation referring to the level of people's capacity for certain decisions was included within the person's care file. The caregiver's we spoke with demonstrated a good understanding of working in people's best interests and gave examples of best interest decision making. A caregiver identified they had raised concerns when a person had not been managing medicines which had led to a best interest meeting and covert medicines being introduced. A caregiver told us; "We assume people have capacity to make their own decisions. Read care plans before providing support. If people haven't got capacity to make certain decisions, people can still be given choices. We don't restrict people."

We checked to see how people were supported to maintain adequate nutrition and hydration. This was an area, which was covered during the initial assessment process where it would be determined if people needed support in this area. We saw in people's care plans that it identified who was responsible for preparing food and drinks for people and what people's food preferences, likes and dislikes were. A person told us; "They always ask what I want preparing first and prepare what I've asked for."

Is the service caring?

Our findings

The people and their relatives who used the service told us they were happy with the care and support they received. Comments included; "The service is good. I wouldn't want to change. Person is happy with them and has got used to them. It would upset things to go with somebody else."; "I'm happy with the care and would recommend the company. The care staff are outstanding. The office staff would benefit from some improvement though." "We wouldn't want to be with anyone else."

The results of the 2016 satisfaction survey indicated an overwhelmingly positive result. 100% of people that responded recorded that they would recommend the service, that their caregiver was introduced to them before care commenced, that they took an interest in them as a person and were well matched to their needs. 92% regarded the quality of the service as good or excellent and that their caregiver goes the extra mile to make a positive difference.

We found people were supported by a small staff team which meant people were provided continuity of care. We found bonds had formed and caregivers understood people's needs. The caregivers had a good knowledge of the people they supported and spoke about people with fondness. A caregiver said; "I care in general so I channel that. I love what I do, making a difference to people's lives. I feel privileged. As long as I leave the person happy, relaxed and contented, I'm happy."

The management maintained a log of people's birthdays and birthday cards were sent to mark the occasion to people receiving support, their immediate family and caregivers.

Caregivers were matched with the people they supported so they had things in common. Caregivers completed a matching tool for each person supported that considered; personality, skills needed, support needed and shared interests. Caregivers were matched through application and interview so they could meet people's needs and promote close bonds and understanding relationships.

We looked to see how the provider recognised equality and diversity and maintained people's human rights. We saw initial assessments were designed to capture this information but nobody in receipt of support from the service at the time of the inspection identified with being LGBT (Lesbian, gay, bisexual or transgender). People receiving support were predominantly from Wigan and were white British heritage. Assessments captured people's cultural and religious needs and identified whether religion was important to the person and what considerations needed to be taken in to account to maintain this. The management were also working in conjunction with another agency to start looking at support for people living with dementia and visual impairments to develop the service to meet their needs based on best practice.

Caregivers took the time to get to know what people enjoyed and how they liked to be cared for. A caregiver said; "We aim to enrich people's lives. Support people to maintain a positive state of mind. We build trust by engaging in conversation, nothing too personal. I might say what I've been doing at weekend and ask people about themselves."

We looked to see how caregivers promoted people's abilities and encouraged people to maintain their skills and independence. Caregivers comments included; "The person isn't the diagnosis. We work around that and empower people to still do all the things that they can do for themselves."; "I always support client to continue doing tasks that they are capable of performing and which is their routine. I support by letting the client do things while I remain present as support, or do it with client, improvise it into a team work if client struggles. Example, making sure client is mobile and safe in their own home for daily routine such as going to bathroom, bedroom, making a drink."

A person had developed in confidence because of how their caregiver had supported them. They had enjoyed knitting but had lost confidence as they had forgotten things. The caregiver had taken wool to the person and suggested following an uncomplicated pattern together. The person had achieved this and had resumed knitting on their own. They had also started to try different knitting styles and were identifying things that they would like to knit rather than relying on the caregiver for direction.

Another person living with dementia maintained an aptitude with their hand and eye coordination despite forgetting other activities of daily living. Their caregiver provided opportunities to make things and they assisted with household tasks. For example, folding up table cloths and towels.

A caregiver told us about a person they supported that had recently been discharged from hospital. The person had professionals involved to provide rehabilitation support. The caregiver told us; "A person is taking steps again. I'm not responsible for it, there are professionals there but I'm there encouraging them when they are struggling. I remind them of all the reasons that they are doing it and it seems to spur them on."

We asked people and their relatives if they were treated with dignity, respect and given privacy by at the times they needed it. Comments included; "[Person] is definitely happy with them. I've no concerns." "They are very respectful. I am very comfortable with them. I usually have two staff and one is always female to help me with that kind of stuff."

Caregivers told us their considerations when maintaining people's privacy and dignity. Comments included; "I always ask for consent and wait to gain this before doing anything. I always give the person choices/options; shower or bath. It's about what the person prefers. [Person] is not undressed and remains covered until the bath is run to protect their dignity. I'd prompt the person to use the toilet but then leave and close the door so they had privacy." "I've been in the community when a person was incontinent. I maintained their dignity by being discrete. I walked behind the person and we put their coat around them whilst we got them to the toilet. I gave reassurance as they were a little embarrassed but we got it sorted and nobody around was aware what had happened."

The service did not provide end of life care directly but, where applicable, could continue to provide a domiciliary service in support of other relevant professionals such as district nurses, who may be involved in supporting a person at this end stage of life. At the time of the inspection the service was not supporting anyone who was in receipt of end of life care but the company was signed up and liaised at a National level.

Is the service responsive?

Our findings

We asked people and their relatives whether they had been involved in an initial assessment of their needs before care and support was provided. Comments included; "My family member did all this for me and set things up. They were involved and answered the questions and provided the information required regarding what support I needed."; "We met first and discussed how support would be provided."; "They asked a lot of questions and found out what was needed before visiting."

We looked at four care files and saw that each person had received a full assessment prior to support commencing. The initial assessment captured a range of information including; important relationships, people's mental capacity, health needs, mobility, communication, and support needs. From the initial assessment, detailed assessments were undertaken and support plans developed. The support plans included personal histories and background information, and people's preferences were captured regarding how people wanted their care to be delivered. This meant people and families had been provided an opportunity to communicate their needs to inform personalised care planning.

People's care files reflected people's abilities and gave detailed guidance for caregivers on how people preferred their care to be given. The care files were organised in to sections for each area of need which made navigating the care file simple and information readily accessible. The sections numbered one to six included; 'My one page profile' which detailed people's likes, dislikes, what is important to me and how to support me. The remaining sections contained information for caregivers on how to provide support in regards to; daily routines, activities and social inclusion, meal preference and dietary requirements which captured details such as whether people preferred warm/cold milk on cereal. The final two sections provided information and plans for managing people's mobility and health conditions

Caregivers told us they were provided the time to read people's support plans before they were introduced to people so they knew about the person and their needs before they met them. People told us they were always introduced to caregivers before they commenced providing care.

There was useful information captured in the care files regarding appliances in people's homes. Photographs were taken and detailed guidance documented which provided useful instructions to ensure caregivers had the required information to operate the appliance. We saw this information captured for: the shower, microwave, cooker and washing machine.

We saw people's care had been reviewed in conjunction with them and their families. Reviews and quality assurance monitoring was undertaken to provide people and their relatives the opportunity to provide feedback regarding the quality of the service received.

The service had actively built links with the local community to enhance people's sense of wellbeing. People were signposted to dementia cafes and befriending services. Management told us that people were supported to engage in activities of their choosing. Caregivers gave us examples of how they had sought

opportunities to reduce social isolation and enhance people's quality of life. One person supported had poor mobility and as a result had become isolated. The person liked to talk and had led an interesting and varied life. The person's family kept telling them they should write a book. The person has commenced capturing their experiences with the assistance of the caregiver whom they told their story and the caregiver made notes. The caregiver told us it would be a book for family to remember and enabled the stories to be captured. The caregiver expressed that this was enriching the person's life and explained they were developing something which they verbalised they enjoyed.

Another caregiver told us they mostly supported people on walks as fresh air was good for people living with dementia. They told us they would sit by a café and just watch people. They had also taken people to the driving range, football, museums, garden centres and the memory centre to watch old films, plays and singers. There was also a pub in Billinge that held a dementia afternoon once a month where people were provided the opportunity to visit.

The provider had an appropriate complaints policy in place, which was outlined in the service user guide and given to everybody who used the service. We noted that since the date of registration the service had not received any form of complaints regarding any aspect of service provision. There was a complaints file in the office so the manager could track these if received. The complaints process was revisited at team meetings so caregivers had access to the required information. We also saw that the complaints procedure had been explained to people at reviews and clarification sought that people were aware of the procedure. A caregiver told us; "I haven't received any complaints about the service. Personally I've received only praise. It makes the job so worthwhile." People and their relatives told us; "I've not had any complaints to make. I'd ring the office."; "I've never had to make a complaint. I receive good care."; "I only raised something with the office once. It was minor and resolved satisfactorily following my call."

We saw the service had received a number of compliments. These included: "Really pleased with support, thank you." "Thank you very much to you all. You really made a difference." "Your kindness and patience helped a great deal." "Very compassionate and greatly supportive. Person sees them as friends and not just carers." "Thank you for noticing when something was not quite right. It's a comfort to know [person] is being so well looked after." "Thank you for all your help and support. I commend the carer for their integrity and good humour." "Thank you for your assistance when I needed you. A big thank you for your caring manner."

Is the service well-led?

Our findings

At the time of our inspection, there was no registered manager in post. The service had a manager that had commenced in post 10 July 2017. They had commenced the process of applying to the Care Quality Commission (CQC) to register. 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.

There was an operational structure in place with the business manager, quality assurance manager and manager overseeing the quality of the service. We found the office was organised and any documents required in relation to the management or running of the service were easily located, well presented and easy to navigate to illicit the information required.

We saw that people who used the service were given a statement of purpose and a service user guide. These documents explained the aims, objectives and structure of the service; in addition to information about the complaints process and fees structure.

Caregivers told us they felt they were able to put their views across to the management, and felt they were listened to. The caregivers we spoke with told us they enjoyed working at the service and said they felt valued. Comments included; "I've always felt able to ring the office. I feel very comfortable. The management are approachable and down to earth. The service approach is good."; "I feel valued by all the staff at the office."; "I do enjoy being a caregiver with HISC Wigan. I feel respected and valued by management."

We saw team meetings were conducted regularly and caregivers told us they felt they were able to contribute to discussions. Team meeting minutes were circulated and kept in caregivers' personal file if they had been in attendance. A caregiver said; "Team meetings are flexible. We can raise issues and can have our say." We saw the discussion at team meetings included: quarterly issues, training portal, feedback, workbooks, professional boundaries, holidays, scheduling, gray matters -online training, certificates, activity logs, IQ timecard, dementia training, medication, emergencies and out of hours contacts.

We saw within staff files we looked at that staff competencies were checked regularly. Spot checks were carried out frequently to help ensure people who used the service and their families remained satisfied with the care delivery.

Regular care plan reviews and questionnaires also helped to ensure quality of care and appropriate care delivery was maintained.

People and their relatives were given the opportunity to comment on the level of service provided by Home Instead Senior Care. People received quality assurance telephone calls or visits each year followed by a further two quality assurance reviews each year.

Internal audits were conducted by the manager and head office audits undertaken bi-annual which concentrated on a 10% sample of people receiving support. These covered a variety of topics such as, staff's knowledge of people's care plans, communication between the office and clients, client and staff compatibility and any additional support required. In addition an annual survey of people using the service was completed by an independent company with the results reviewed, analysed and published for people to read.

An annual internal audit was completed by the provider's national office, which checked all paperwork completed. This audit ensured the franchisee was completing the required documentation to the required standard. Any recommendations were contained in an action plan that the provider reviewed on a monthly basis to ensure a continuous process of improvement.

We looked at the responses received and found feedback from people who used the service and their relatives was very positive.

Caregivers also provided feedback through satisfaction surveys. Results obtained from the last survey indicated; 100% of responses from caregivers said they were given enough time to deliver desired levels of care to clients. 96% felt well matched to people supported and 85% recognised the service was different to other care companies. 88% of caregivers stated they were proud to work for the agency and would recommend the agency as a place to work and to friends or family requiring a care service.

All policies and procedures were England specific and at the last stage of review at the time of inspection. The policies had electronic links to legislation, social policy and Nice guidance.

Providers are required by law to notify CQC of certain events in the service such as serious injuries, deaths and deprivation of liberty safeguard applications. Records we looked at confirmed that CQC had received all the required notifications consistently and in a timely way.