Focal Care limited

Caremark (Barnsley)

Inspection report

Unit 8b,
Redbrook Business Park
Wilthorpe Road
Barnsley
South Yorkshire
S75 1JN
Tel: 01226 242858
Website: www.caremark.co.uk

Date of inspection visit: 11 to 12 August 2014
Date of publication: 16/12/2014

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

Overall summary

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008 and to pilot a new inspection process being introduced by CQC which looks at the overall quality of the service.

The inspection was announced. The service was last inspected on 2 July 2013 and was meeting the requirements of the regulations we checked at that time.

Caremark (Barnsley) is a domiciliary care agency registered to provide personal care to people in their own homes. Those using the service include people living with dementia, people with complex needs and people with mental health needs. At the time of our inspection, 219 people were using the service.

Summary of findings

There was a registered manager in place at the service. A registered manager is a person who has registered with the Care Quality Commission to manage the service and has the legal responsibility for meeting the requirements of the law; as does the provider.

People using the service told us they felt safe and comfortable with their care workers. Staff had a good understanding of safeguarding and knew how to recognise, and protect people from abuse. They received training in safeguarding and the Mental Capacity Act 2005. The service reported any safeguarding incidents to the local authority as required.

Individual risk assessments were completed for people so that identifiable risks were managed effectively. People were included in the completion of these and they were reviewed regularly and in response to changes.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. Staff told us there were sufficient staff on duty to meet people's needs. However, when visits were missed, the current system in place did not always identify when this occurred. This meant there was a risk of people not receiving support when they needed it. The service was looking to introduce electronic call monitoring which would alert in real time when calls were missed.

Staff completed induction, training and received ongoing support. They had opportunities to undertake further training to ensure they were able to meet people's individual needs. People were supported to maintain good health and staff sought advice and information from other health professionals in relation to people's care.

People and relatives were predominantly positive about the care and support they received and the individual care workers providing the support. They told us that staff respected their privacy and dignity and acted upon their preferences which were recorded in their care files. However, they were concerned about the high turnover of staff which meant care workers often changed. People said they would prefer to have the same care workers to support them for consistency and in order to build up relationships.

People's care and support needs were assessed before they started receiving support and where people's needs changed, support was adjusted to accommodate these changes.

People and relatives we spoke with were aware of how to make a complaint or raise a concern. They had information available in their care files detailing the service's complaints procedure. All said they would feel comfortable in raising any issues.

Staff felt supported by the manager and directors. Team meetings were frequent and good practice was shared to help the service improve. Accidents and incidents were monitored by the manager and the service to ensure any trends were identified. There were effective systems in place to monitor and improve the quality of the service provided.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe. People told us they felt safe. Staff had a good understanding of safeguarding and knew how to protect people from abuse. They received training in safeguarding and the Mental Capacity Act 2005. The service reported any safeguarding incidents to the local authority as required.

Staff at the service enabled and supported people to take responsible risks. Assessments were completed so that identifiable risks were managed effectively.

Robust recruitment procedures were in place and appropriate checks were undertaken before staff started work. Staff told us there were sufficient staff on duty to meet people's needs. However, when visits were missed the current system in place did not always identify when this occurred.

Is the service effective?

Good

The service was effective. Staff had completed induction, training and received ongoing support. Staff had opportunities to undertake further training to ensure they were able to meet people's individual needs.

Nutritional requirements were identified when people were assessed. People preferences about what they liked to eat and drink were recorded. Where people had specialised diets, care plans were produced in respect of these.

People were supported to maintain good health and staff sought advice and information from other health professionals in relation to people's care.

Is the service caring?

Good

The service was caring. People we spoke with said they were happy with the care provided and could make decisions about their own care and how they were supported.

People and relatives told us they were supported by caring staff. However, people were concerned about the high turnover of staff which meant their care workers often changed. People said they would prefer to have the same care workers to support them.

Staff were aware of the values of the service and knew how to respect people's privacy and dignity.

Is the service responsive?

Good

The service was responsive. People's care and support needs were assessed before they started receiving support. Care records detailed people's preferences, interests, likes and dislikes. Where people's needs changed, support was adjusted to accommodate these changes.

People were supported to take part in activities and to engage and interact with services in the local community.

People and relatives we spoke with were aware of how to make a complaint or raise a concern. They had information available in their care files detailing the service's complaints procedure. All said they would feel comfortable in raising any issues.

Summary of findings

Is the service well-led?

Good

The service was well led. There were effective systems in place to monitor and improve the quality of the service provided.

Staff felt supported by the manager and directors. Team meetings were frequent and good practice was shared to help the service improve.

Accidents and incidents were monitored by the manager and the service to ensure any trends were identified.

Caremark (Barnsley)

Detailed findings

Background to this inspection

This report was written during the testing phase of our new approach to regulating adult social care services. After this testing phase, inspection of consent to care and treatment, restraint, and practice under the Mental Capacity Act 2005 (MCA) was moved from the key question 'Is the service safe?' to 'Is the service effective?'

The ratings for this location were awarded in October 2014. They can be directly compared with any other service we have rated since then, including in relation to consent, restraint, and the MCA under the 'Effective' section. Our written findings in relation to these topics, however, can be read in the 'Is the service safe' sections of this report

The inspection took place on 11 and 12 August 2014. The provider was given 48 hours' notice because the location provides a domiciliary care service. Therefore we had to pre-arrange visits to people's homes as well as arrange for care staff to attend the office and speak with us on the days of the inspection.

The inspection team consisted of two adult social care inspectors and an expert by experience whose area of specialism was social care. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before our inspection, we reviewed the information we held about the service and contacted the commissioners of the service for any relevant information they held. We asked the provider to complete a Provider Information Return which contained detailed information about the service. This information was reviewed and used to assist with our inspection.

As part of our inspection we visited eight people, with permission, in their own homes. The expert by experience and an inspector spoke via telephone with a further 18 people using the service. We spoke with a social worker and a specialist nurse who had involvement with individual people who used, or were using, the agency.

We spent time at the office and spoke with the operations director and the finance director. We spoke individually with five care and support workers and the recruitment officer. We reviewed records which included ten care files, staff files, meeting minutes, policies and procedures and other relevant documentation.

Is the service safe?

Our findings

All staff completed safeguarding training as part of the induction program they undertook when they commenced employment with the service. This training was facilitated by the local authority and we saw evidence of completion in the staff files we viewed. Staff demonstrated they were familiar with the different types of abuse, knew how to report these and what their responsibilities were. All said they would report any concerns immediately to their manager. This meant that staff understood how to protect people from avoidable harm and abuse.

During our inspection, whilst spending time in the office, we became aware of a safeguarding incident (unrelated to staff) that a care worker had witnessed on a visit. This was immediately reported to a senior staff member, the office and to the police. The operations director in turn reported this to the local authority. CQC subsequently received a formal notification about this incident in line with the requirements for statutory notifications. We also saw evidence of previous and current ongoing safeguarding referrals which the service had reported promptly to the local authority. This demonstrated that the service adhered to correct procedures for safeguarding and maintaining people's safety.

There was a detailed safeguarding policy at the service and staff had information about the procedures to follow. An employee handbook was issued to each staff member. Safeguarding was an agenda topic at team meetings which we saw evidence of in minutes. The service had a whistleblowing policy and this subject was also covered at induction. Whistleblowing is when a worker reports suspected wrongdoing at work. Staff said they would feel comfortable in reporting any concerns they had to their supervisor or management.

The Mental Capacity Act (MCA) 2005 is legislation designed to protect people who may not be able to make some decisions for themselves. Staff received training in this subject as part of their induction. Staff knowledge pertaining to this act varied amongst the five care workers we spoke with. Three had a clear understanding of how the act applied which meant they had knowledge to ensure decisions were made in people's best interests and in line with required procedures. Two staff were unable to describe what the Act entailed. However, all said they would seek advice from management and guidance from a person's family, friends and advocates if they had concerns about a person's capacity. The Mental Capacity Act code of practice and relevant procedures were available in the office for staff to access.

There was a policy in place for 'Managing Challenging Behaviour' and staff received training in this. This meant they were equipped with skills and knowledge to deal effectively with behaviour that challenged the service. Directors told us they also assessed risk to staff and put processes in place to minimise risk such as 'double handed calls' (two care workers attending) where this was required.

People we spoke with who used the service told us they felt safe. They told us that senior staff came out to check they were happy with their support and their care workers. One person said, "We have telephone numbers in the folder to contact the agency should an emergency occur." We confirmed that people had named contacts and numbers in the care files that were kept in their homes. People told us they felt comfortable with their care workers. One person said, "We've never had any bad ones."

Staff and people who used the service told us they were always able to get hold of someone when they needed support or assistance which showed the service had measures in place to deal with unforeseen circumstances.

With permission from the people we visited, we looked at the care files kept at their homes in addition to a sample that were stored at the office. Each person had individual risk assessments in place which were personalised to their care and support needs. For example, there were risk assessments that related to eating and drinking, mobility and personal care. These were designed to ensure that potential risks to people were managed whilst still promoting independence and personal choice. These were reviewed at regular intervals and in response to any changes in risk. Additional risk assessments were implemented where required. We saw evidence of involvement from people in their risk management plans.

The business director told us of other ways the service promoted people's safety. One example given was of joint working with the South Yorkshire fire and rescue service whereby some care staff had undertaken training with the service. This allowed them to recognise potential safety hazards in people's homes. This would then assist them in making referrals, with people's consent, to the fire service for people to have a home safety check. Staff also

Is the service safe?

signposted people to the local 'assistive technology team' which some people using the service were not aware of. This then allowed people to explore other ways of promoting their safety by the use of technology. This demonstrated that the service sought to work with other organisations in order to promote the safety, independence and wellbeing of people.

The service used a software package to allocate staff to calls which did not require any communication from staff to confirm when they had arrived at their visit. As a consequence of this, and due to the number of people using the service, we saw several instances of recent missed calls. For example there were ten missed calls since June 2014, five of which occurred on one day where the care worker scheduled for the visits was not at work. Upon discovery, we saw that arrangements had been put in place to cover the calls and they had been notified to the local authority. Missed calls were only discovered if a person, or friend or family member, realised the call had been missed and were able to alert the office. One person we spoke with told us of a time last year when no-one had turned up for two scheduled visits. They said they were able to contact the office who eventually sent someone out. However there was a risk that people who were not able to, or did not, contact the office may not receive their support. The directors we spoke with were aware of this risk and told us they were in consultation with a supplier to introduce electronic call monitoring. This was being rolled out in a phased program and was due to be fully implemented by early 2015. This meant they would be alerted if any calls went unattended which would prevent people from not receiving support when they required it.

Staff told us they felt they had enough time to provide care for the people they supported and they felt there were enough staff to meet people's needs. At the time of our inspection the service had several care staff vacancies that they were actively looking to fill. The majority of the people we spoke with told us they had not had any missed calls, however they did comment on turnover of staff. One relative whose family member had complex needs told us of instances where the service had not been able to provide suitably trained staff for care visits. They felt the agency may "be taking on more work than they can handle." We discussed this matter with the directors who said they were working with this person and their family to address this situation. They told us this was in part due to numbers of staff with the required specialised training. Unforseen instances where these staff members were sick or left the service sometimes led to occurrences the relative told us about. The directors and manager were working with the local authority to look at contingency measures that could be implemented. The relative told us that their situation had recently improved and was now getting better.

The service employed a recruitment officer who was responsible for the appointment of new staff and told us about the different stages of recruitment. We asked the care workers we spoke with about the recruitment procedure they went through prior to commencing employment. This matched the process explained by the recruitment officer. All staff said they had to supply references and that a Disclosure and Barring Service (DBS) check had to be carried out prior to them starting their role. (The Disclosure and Barring Service carry out a criminal record and barring check on individuals who intend to work with children and vulnerable adults, to help employers make safer recruiting decisions and also to prevent unsuitable people from working with children and vulnerable adults). Staff said they had to wait until this information had been returned and was satisfactory prior to starting their employment.

We looked at five staff files and confirmed that all relevant information was in place. This included prior employment history, employment references and evidence of DBS checks. This meant that staff had been recruited in a way to ensure they were safe and suitable to work with the people they supported.

Is the service effective?

Our findings

All staff followed a structured induction program when they commenced their employment. Staff told us this consisted of several days of training in key subjects including safeguarding, moving and handling, health and safety and first aid which was delivered by a local authority accredited trainer. The operations director told us training was classroom based so that staff had opportunity in a group environment to confirm their understanding and consolidate their knowledge. Staff told us they found the induction beneficial and informative. One care worker said, “The training was brilliant, the trainer kept it fun, engaged us and we learned a lot." This showed that staff were equipped with relevant skills and knowledge to be able to perform their roles effectively.

New staff undertook a shadowing period with experienced staff prior to being formally assessed as competent to work alone. One care worker told us, “The managers will ask if you feel confident before signing you off, they don’t shove you in at the deep end.” Staff told us they were fully supported throughout this process.

Training was provided by the local authority and by an independent provider. The directors told us training was refreshed at set intervals and said they would access additional training for staff that was relevant to their role. For example, dementia awareness and end of life care was offered and some staff had completed training in this. The service supported some people who had complex needs and required specialist support. Care staff working in this area received specific training so that they were able to meet people’s needs. One care worker told us how they had received some bespoke training at a specialist hospital which showed that the service utilised and facilitated training opportunities for staff.

All staff had the opportunity to obtain a formal qualification in health and social care and staff told us they were encouraged to access further training. One care worker was currently undertaking further training to become a dementia champion which would allow them to train others in good dementia care practice. This demonstrated that staff had opportunities to widen their skill sets and to progress in their roles.

Staff had regular supervisions and annual appraisals which we saw evidence of in staff files. Staff told us they valued formal supervision meetings and informal support. They said they were able to discuss a variety of topics which included what was going well, what was going not so well and whether they required or wanted to access any further support or training. By receiving appraisals, staff had defined objectives they could work towards.

People felt their needs were met by staff who knew what they were doing. Comments included, “In my opinion the carers are trained to do their jobs” and “The staff are able to use the equipment to get my husband in and out of bed.” One person said, “My carer was made aware of the side effects of the medicines I am taking and I am pleased that she also knows, as we can both look out for the signs should anything goes wrong.” Another person said, “They seem competent, know what they’re doing.”

People were supported with their nutrition where required, and this was documented in people’s care plans which we saw evidence of. Information was contained about people’s nutritional likes and dislikes. The operations director told us that nutrition and hydration sheets were implemented where this information needed to be monitored. Where people were on specialised diets, a care plan was produced around this so that it was clear what support the person needed.

The directors and care staff told us of training they received, and joint working with other health professionals to ensure people’s health needs were met. Staff told us they sought advice, and worked in conjunction with, district nurses where they were working to support the same people. They told us that if they felt a person’s health needs had changed they would alert their supervisor or a manager so that appropriate referrals could be made. Care workers working with people with complex needs often worked with other professionals such as specialist nurses, occupational therapists and physiotherapists.

We spoke with a social worker and a specialist nurse who had involvement with the service. One told us of some occasions where care staff who did not have the required skills had attended to support a person who required specialist support. The other told us how the service had been pro-active in helping to support people.

Is the service caring?

Our findings

People using the service and relatives were positive about the care they received. Comments from people we spoke with included, "Nothing but admiration for the whole service. I'm amazed at how kind and caring the carers are. They're ready to please, I'm in awe of what they do", "They are very caring, brilliant carers" and "I have always felt they are doing their job well and we have been with the agency for two years." People were equally positive about the staff by saying, "All top class, they're lovely", "They're all pretty good, polite and respectful" and "They're always very nice and chatty."

People told us they had choice in their support. One person said, "My husband has a male carer as this is his wish." The directors told us how they tried to accommodate people's wishes and respected the diverse needs of people based on factors such as their culture, gender, religion and disabilities. The operations director told us how they tried to match people in a number of ways which included looking at whether people and staff had similar interests. People were supported by staff they felt comfortable with. One relative told us how their family member who used the service did not get on with one of their care workers. They said the staff member did nothing wrong, but that it was just a "personality clash". They made a supervisor aware of this and the care worker was changed to someone who more suited to the person using the service.

All people we spoke with and visited confirmed they had a care file at their home. One person told us, "My care plan is in the folder." A relative who was supporting a person we visited told us they always checked the care plan when they visited and had no concerns. Another relative said, "We were able to contribute to the care plan once it was established that mum would be needing home care." Other people we spoke with told us, "I am aware that the care plan details my likes and dislikes and this seems to be working" and "My family and I have contributed to the care plans and this assists the carers to meet my needs." This demonstrated that people had active involvement and influence in the care they or their family member received.

We saw that care plans contained person centred information about how people liked to be supported and information about the person's likes and dislikes. Background information, personal history and interests were covered in order to provide a holistic view of the person. We saw a new document that was being implemented throughout people's care plans. This document was titled 'I am' and provided a snap shot of the person's care plan by condensing key information so that staff would know what was important to the person. This included information about 'who knows me best', 'what I would like you to know' and 'my home, family and things that are important to me'. This document reflected current good practice for supporting people and helping to put the person's needs and preferences at the centre of their support.

Staff told us that they predominantly supported the same people which allowed them to build up relationships with people. However, from speaking with people using the service it was evident some people had experienced lots of changes of care workers. This resulted in a lack of consistency and continuity for some people. One relative told us, "I would like a regular carer for my husband so we can build a relationship." People commented that there appeared to be a "high turnover of staff" and that staff didn't seem to stay long. Another person said of their care workers, "It's not really good to have different ones, it would be better to have the same ones." People said the impact of this was that they didn't always have time to build up relationships and trust with their care workers. One person said they had recently got "Two new ones, [care workers] really nice, but we're worried they'll leave." Another person said, "I keep seeing different ones, they bring a lot of new ones, young girls." Some people told us this had recently started to settle down so that they had the same staff. One person said about their family member's care, "When he first started, he used to get different people. We get more regular ones now, can start to gel with them."

The directors were aware that there was an issue with staff turnover which in turn impacted upon continuity of care for people they supported. The directors and manager ensured that where a person was to be supported by a care worker they had not met before, an introduction was made by a staff member familiar to the person. Staff said they were directed to notify a manager if someone new to them was included on their rota so that an introduction could be arranged. The care staff we spoke with said they had never been asked to support someone

Is the service caring?

without having been introduced to them beforehand. People we spoke with confirmed that they would normally be introduced to new staff by a staff member they were familiar with.

All people we asked told us that staff respected their privacy and dignity at all times. People and relatives gave examples of how they achieved this. They told us, "I am called by my first name because I have given them [staff] permission to do so", "The lady that comes always hangs her coat at the back of the door and never chucks it on the settee and I see this as respectful" and "I am always spoken to kindly when I have my daily personal care." Another person said "I am treated as an adult and they [staff] are all courteous." When we spoke with staff they were able to give examples of how they preserved people's privacy and dignity when providing support. One care worker told us, "I am a guest in people's homes, I always ask permission before doing things and respect people."

Is the service responsive?

Our findings

Care was assessed and planned in response to people's individual requirements. This was completed by way of a needs assessment being undertaken with the person, and their family and advocates where appropriate. People told us that prior to starting the service, someone came out to discuss what support they required. One person said, "The agency manager came and made an assessment of my mum's needs, including any risk. The carers come three times a day now and we are satisfied how this has worked out." We saw evidence of needs assessments in the care records we viewed.

People's care was reviewed periodically by the service. We saw evidence of reviews of people's care and support in the care records that we looked at. People confirmed that they had reviews of their care by way of supervisors checking that support still met their needs. People were able to make changes where required. One person told us, "My care plan was reviewed two weeks ago and I am now getting three visits a day instead of two because I am needing more help." The majority of people told us they could make changes where required and the service would act upon and implement these. One person we spoke with told us they felt they were competent to deal with their own medication, a task which care workers assisted him with. We looked at this person's care file which showed previous reviews had shown they were satisfied with their care and their needs had initially been assessed by way of a local authority community care assessment. We made the directors aware of this person's comments and they advised they would look into the situation to establish whether any adjustments were required for the person.

Care workers told us they would inform the registered manager if they felt a person's needs had changed. They said they would also advise and discuss, where appropriate, any changes with other individuals involved with the person; for example, family and other professionals. We saw an example in a care plan we looked at where a care-co-ordinator had requested an occupational therapy assessment for a person in response to care workers noticing deterioration in the person's mobility. One care worker we spoke with told us about a person they supported whereby the visit times scheduled were not long enough to complete the care the person needed. They fed this back to their supervisor and with input from relevant professionals, the person's needs were re-assessed and the visit durations amended accordingly. These had now reduced as the person became more able to do things for themselves. This showed that care workers were able to recognise and act upon changes they identified, in order to ensure support was tailored to people's needs.

The specialist nurse we spoke with said that the service met regularly with one person they supported with complex needs and their family. This allowed an open discussion around their care needs and whether any amendments were required which the professional found useful and considered to be a positive measure. We spoke with this person's relative who confirmed that these meetings took place. They said they could bring these forward if required in response to any changes or issues that needed to be addressed.

Care workers told us they stayed for the amount of time they were scheduled for and said if they were running over they would inform their supervisor. People we spoke with told us staff were usually on time or if they were running late, they would be informed. Staff were described as "good timekeepers". Two people, whilst positive about the majority of the care workers told us, "One of them wants to leave in hurry. The others know what they're doing though" and "I don't think they have enough time, one or two seem to rush off." The majority of people we spoke with told us staff stayed for the amount of time they were meant to and always asked whether the person wanted anything else doing. One person said, "They always check with me before they leave if there's anything else I want. I prefer to manage on my own when I can and they leave me to do that." The majority of people felt staff responded to their needs and acted upon their requests to provide care personalised to them. One care worker told us of a person who was physically unable to prepare meals. They said, "I always get a few choices out of the fridge or freezer and show him the items so he can see for himself and decide." This showed that people's individual choices were sought and responded to.

People were supported and encouraged to maintain and participate in activities they enjoyed. The operations director told us how people were supported to undertake recreational activities in the community. This included trips to the cinema, garden centres, college, cinemas and appointments. One person we spoke with told us how they

Is the service responsive?

liked to bake with their care worker and told us about karate classes they attended. This meant people were still able to enjoy and participate in their usual routines and activities.

The service had a detailed complaints policy in place and there was an easy read format available for people who required it. This set out the procedures to follow to make a complaint and timescales for a response. We saw a copy of the complaints procedure was in people's care records in their home so they had information available first hand. One relative we spoke with told us they had previously made a complaint in relation to a care worker. They said, "I discussed this with the agency manager and the carer was changed. We viewed this as a positive step." Everyone we spoke with told us if they did have any complaints, comments or concerns to make, they would feel comfortable in speaking to a supervisor or the manager. We saw that complaints people made had been acknowledged, investigated and responded to appropriately by the manager. The operations director told us that complaints were reviewed in both monthly operations and directors' meetings. This was to identify any trends and themes and to help prevent further occurrences of a similar nature.

We saw evidence of people being encouraged to provide feedback by way of annual questionnaires being sent to people using the service. We saw various compliments and comments from people who praised the service and the care they had received. The directors told us that survey responses were analysed by the service's compliance administrator to look for any themes or trends. The manager would also review responses to identify and address any feedback that warranted further action.

Is the service well-led?

Our findings

The service had a clear management structure in place which was overseen by the two directors we spoke with during the inspection. Both were based at the office alongside the registered manager and other office based staff.

Since our last inspection of this service, several new roles had been created to cope with expansion of the organisation. These included a recruitment officer and a compliance officer whose focus was on documentation and quality assurance. The directors told us they had identified a need for these positions and these were developed to ensure the service ran effectively and met the needs of people who used it. This showed recognition of the importance of responding to change to ensure the service was well led.

The registered manager was not present on the dates of our inspection so our information around the management of the service was based on discussions with the directors, staff and people using the service. Care workers we spoke with each had a named field care supervisor as their immediate line manager. All said that they got good support and guidance from their supervisors. One person said of their supervisor, "She's really good. She calls me often to make sure I'm ok". Each care worker told us they would feel comfortable and happy to contact the registered manager should they need to. Care workers said of the manager, "She's brilliant. She has an open door policy. I'm the happiest I've ever been working here. I get lots of support". Another said they got full support from management and said, "I can speak to the [manager] or the [director] anytime, no problems" and "[Director] gets involved with staff. So supportive as a group here, they make you feel very comfortable". No staff we spoke with had any negative comments about their seniors and the management team.

From our observations whilst spending time in the office, it was clear that there was open communication between the directors, office staff and care workers. The directors told us they endeavoured to provide clear direction to staff and encouraged them to promote professional behaviours, honesty and transparency. They said, "We want likeminded staff that the share the same values as us".

One social worker we spoke with from the local authority said they had positive experiences of the service. People and relatives we spoke with had contact details of the office and a named supervisor they could contact directly. Some people told us of meetings they had had with the registered manager. One person said "[Manager] is very approachable, she's been here lots of times". Another person said of their care workers, "My young ladies always appear happy and do a good job and this says to me that the manager is good". However, another person suggested that "the high turnover of staff" indicated a problem with the organisation's approach although they had no issues with the staff that came.

A staff newsletter was circulated quarterly with relevant updates and information for staff which included new appointments, information about training, congratulations and 'directors' comments'. Team meetings regularly took place and this was confirmed by the staff we spoke with. Staff said they had an agenda but could speak about any matters they wanted to in addition to this. We saw minutes of team meetings which were detailed and showed that a number of topics were covered. Where staff were unable to attend meetings, they received minutes of these to ensure they were aware of latest information. Meetings were also used as a forum to share best practice. For example we were told about a specialist nurse in Parkinson's disease and a representative from the Alzheimer's society who had previously attended team meetings to share information with the team. This showed that the service was proactive in working with other specialists and organisations to share and implement best practice.

The operations director told us that customer service reviews took place every six weeks for each person using the service to ensure the care they received was appropriate and suited their needs. These checks included audits of the documentation in care files in addition to assessing the support being provided. We saw evidence of these checks present in people's care files and saw where actions had been identified for follow up and completed. This demonstrated that the service continuously monitored the service and looked for ways as how this could be improved.

We saw that spot checks were undertaken to ensure staff members were providing appropriate care and to identify any areas for improvement. Staff told us that they received feedback about their work. One care worker said, "I take

Is the service well-led?

pride in my work and do it to a high standard. I've had a few compliments and my supervisor always passes these on to me". Another said, "We get recognition for good practice and it goes on file as well". This meant that feedback was shared with staff to allow them to reflect on their practices and understand what they did well and where they could improve.

Feedback was obtained by way of questionnaires, quality assurance monitoring and reviews. People and relatives told us they would feel comfortable in giving their care worker or supervisor any feedback they had about the service. One relative we spoke with told how they and their family member were able to influence decisions about the staff who provided support by way of assessing the staff during shadowing shifts as to whether they were suitable or not. They told us they would have liked to have had more input at an earlier stage if possible, and made the management aware of this, but nothing had been done to facilitate this. This demonstrated that although people had opportunities to influence the service, there was still room to explore this further specifically to people's requests.

Any accidents and incidents were monitored by the registered manager and the organisation to ensure any trends were identified. The service operated an on call system where senior staff worked from a rota to act as a point of contact outside of office hours.

The directors and the registered manager were aware of their responsibility to inform the CQC about notifiable incidents and circumstances in line with the Health and Social Care Act 2008.