Concept Care Solutions Limited

Concept Care Solutions

Inspection report

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Tel: 01702567430

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30 January 2019

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Ratings

Overall rating for this service	Good

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

Summary of findings

Overall summary

About the service:
• Concept Care Solutions is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community. It provides a service to older adults, people with physical disabilities, mental health needs, and dementia.
• The provider had three domiciliary care agencies within their registration.
• At the time of the inspection it was providing a service to 42 people.
• For more details, please see the full report which is on the CQC website at www.cqc.org.uk

People's experience of using this service:
• People were protected against avoidable harm, abuse, neglect and discrimination. The care they received was very safe.
• People's risks were assessed and strategies put in place to mitigate the risks.
• People's likes, preferences and dislikes were assessed and care packages met people's desired expectations.
• Relatives provided consistently positive feedback about the care, staff and management. They said the service was caring, timely, effective and well-led.
• People's care was person-centred. The care was designed to ensure people's independence was encouraged and maintained.
• People and their relatives were involved in the care planning and review of their care.
• The service had a stable management structure. The provider had implemented systems to ensure they continuously measured the safety of people's care and quality of the service.

Rating at last inspection:
• Good (report published on 13 September 2016)

Why we inspected:
• This was a planned inspection to check that this service remained Good.

Follow up:
• We will continue to monitor intelligence we receive about the service until we return to visit as per our re-inspection programme. If any concerning information is received we may inspect sooner.
• We made a recommendation in our inspection report, which we will follow up at our next inspection.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Good

The service was safe.

Details are in our Safe findings below.

Is the service effective?

Good

The service was effective.

Details are in our Effective findings below.

Is the service caring?

Good

The service was caring.

Details are in our Caring findings below.

Is the service responsive?

Good

The service was responsive.

Details are in our Responsive findings below.

Is the service well-led?

Good

The service was well-led.

Details are in our Well-led findings below.

Concept Care Solutions

Detailed findings

Background to this inspection

The 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.

Inspection team:
• The inspection team consisted of two inspectors and an expert-by-experience. An expert-by-experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Service and service type:
• Concept Care Solutions is a domiciliary care agency. It provides personal care to people living in their own houses and flats in the community.
• The service had a manager registered with the Care Quality Commission. This means that they and the provider are legally responsible for how the service is run and for the quality and safety of the care provided.

Notice of inspection:
• Our inspection was announced.
• The provider was given 48 hours' notice because the location provides a domiciliary care service and we needed to be sure that someone would be in.
• Our inspection process commenced on 30 January 2019 and concluded on 31 January 2019. It included visiting the service's office and telephoning people who used the service and their relatives. We visited the office location on 30 January 2019 to see the registered manager and office staff, and to review care records and policies and procedures. We telephoned six people who used the service and nine relatives on 30 January 2019 and concluded on 31 January 2019.

What we did:
• Our inspection was informed by evidence we already held about the service. We also checked for feedback we received from members of the public and the local authority. We checked records held by Companies House.

• We asked the service to complete a Provider Information Return. This is information we require providers to send us at least once annually to give some key information about the service, what the service does well and improvements they plan to make. The Provider Information Return was due to be completed by 8 February 2018.
• We spoke with six people who used the service and nine relatives.
• We spoke with the registered manager, the field supervisor, the care coordinator, and eight care workers.
• We reviewed six people's care records, five staff personnel files, staff training documents, and other records about the management of the service.
• We requested additional evidence to be sent to us after our inspection. This was received and the information was used as part of our inspection.

Good

Is the service safe?

Our findings

Safe – this means people were protected from abuse and avoidable harm

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

• People and their relatives told us they felt the service was safe. A person told us, "[Staff] work very hard to keep me safe. I do feel safe when I'm out with them. They guard me with their life." One relative said, "Absolutely I feel that [relative] is in safe hands with them." Another relative told us, "I'm hugely reassured that [relative] is safe in their care, and they have proved that repeatedly."

Systems and processes to safeguard people from the risk of abuse:
• People were protected from the risks of harm, abuse and discrimination.
• There was a safeguarding and whistleblowing policy in place which set out the types of abuse, how to raise referrals to local authorities and the expectations of staff.
• Staff and management we spoke with had a good understanding of their responsibilities. One member of staff said, "We would report to our supervisor. We can report to social worker, and CQC." Another staff member said, "We go directly to the manager."
• Staff completed safeguarding training to provide them with knowledge of abuse and neglect.
• The registered manager was able to describe the actions they had taken when incidents had occurred which included reporting to the Care Quality Commission (CQC) and the local authority.

Assessing risk, safety monitoring and management:
• The service aimed to obtain as much information about a person before a new care package commenced. Before admission to the service a 'initial assessment form' was undertaken to assess whether the service could meet the person's needs. This included assessments from commissioning bodies, and feedback from people and their relatives. One person told us they were pleased with the initial assessment process. The person said that the staff member who had visited them told them, "We think you'd get on with [staff member] because they'd suit your character and interests but if they're not right for you let me know, and we can change it."
• People's care files included risk assessments which had been conducted in relation to their support needs. Risk assessments covered areas such as the home environment, falls, manual handling, medicines, mental capacity, skin integrity, and personal care.
• Staff we spoke with were aware of people's risks and knew how to support people in a safe way, whilst maintaining their freedom. One staff member said, "Update the risk assessment if it needs to be updated. Most of the time the risk assessment is done every six months. If there are changes it has to be reassessed. If risk of falling you have to report that and reassess. Put it in writing, report it, and make a plan to avoid or minimise. Copy of risk assessment is in care notes in [people's] homes."

Staffing and recruitment:
• Through our discussions with the registered manager, staff and relatives of the people who used the service, we found there were enough staff to meet the needs of people who used the service.

• Staffing levels were determined by the number of people using the service and their needs, and could be adjusted accordingly. People told us their needs were met by the staff. One person told us, "[Staff] never seem in a rush to go, they'll stay and have a chat. "One relative said, "[Staff] come mornings and evening. They're reliable, punctual and friendly." Another relative told us, "Once they didn't ring, and when we phoned they were very apologetic saying that the carer had been waiting for an ambulance with a previous [person]. Even so, [relative] wasn't waiting for very long."
• Staff were allocated to calls geographically so that it reduced travel times and was based on where people lived.
• Staff told us there was sufficient staffing levels and their shifts were covered when they were on sick and annual leave. One staff member told us, "Yes [enough time]. Travel time is included. Not rushing anymore." Another staff member said, "If not enough time we would report to supervisor. We can get cover if we need help."
• The provider followed safe recruitment practices.
• Staff recruitment records showed relevant checks had been completed before staff worked unsupervised at the service. We saw completed application forms, proof of identity, references and Disclosure and Barring Service (DBS) checks. The DBS is a national agency that holds information about criminal records.

Using medicines safely:
• The service had a medicines policy in place which covered the recording and administration of medicines.
• Records showed staff were up to date with medicines training.
• Staff shadowed an experienced staff member and then were supervised with giving medicines.
• Not all people who used the service received medicines. Some people required prompting by staff and others required full administration. Prompting and full administration of medicines were recorded.
• Medicine competency checks of staff were undertaken. This ensured they remained safe to continue to administer medicines.
• People who were supported with medicines had a medication administration record (MAR). We found these were accurately completed and showed that people received their medicines as prescribed. One person told us, "[Staff] do my tablets for me, because I can't see very well. They know what they're doing. I never have reason to doubt them." One relative said, "[Relative] has one tablet which is only to be given when she needs it. [Staff] understand that, and if they give her one, they always record why it was given."
• MAR records were returned to the office monthly and audited.

Preventing and controlling infection:
• Staff completed training in infection prevention and control on a regular basis. Records confirmed this.
• Staff had access to personal protective equipment (PPE) such as gloves, aprons and hand sanitizer. One staff member told us, "We always have sanitizers. Always wash our hands after cleaning. We get PPE from the office." Another staff member said, "I have gloves and hand rub."
• Staff were required to complete training in food hygiene, so that they could safely make and serve meals and clean up after preparation. Records confirmed this.

Learning lessons when things go wrong:
• When care workers become aware of any accidents and incidents, they called the office and details were recorded on an incident form.
• The forms were passed onto managers for review and, where necessary, investigation.
• A log of incidents per month was kept, to tally up the number and analyse any trends or themes.
• Where necessary, incidents and accidents were reported to third parties.

Good

Is the service effective?

Our findings

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

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

• One person told us, "I can't fault any of [staff], they're all very good to me, such a friendly bunch of people." One relative said, "This agency seems to be much more qualified with dementia care than [relative's] previous ones. Somehow they just seem to understand [relative]."

Assessing people's needs and choices; delivering care in line with standards, guidance and the law:
• Assessments of people's needs we saw were comprehensive, expected outcomes were identified, and care and support regularly reviewed.
• Staff applied learning effectively in line with best practice, which led to good outcomes for people and supported a good quality of life.
• Staff knew people's preferences, likes and dislikes. Information available included meal choices, and personal hygiene routines.

Staff skills, knowledge and experience:
• When new staff joined the service, they completed an induction programme which included shadowing more experienced staff. One staff member said, "Before we start the job we have training online and in the classroom. We have training meetings. [Senior staff] shadow us."
• Training was provided in subjects including basic life support, COSHH, fire safety, information governance, lone working, handling violence, health and safety, infection control, food hygiene, equality and diversity, manual handling, RIDDOR, safeguarding adults, medicines, care planning and the Mental Capacity Act 2005. Records confirmed this. RIDDOR is the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013. These Regulations require employers, the self-employed and those in control of premises to report specified workplace incidents.
• Staff told us the training provided helped them to perform their role.
• Records showed staff completed The Care Certificate. The Care Certificate is a set of standards that social care and health workers use in their daily working life.
• Staff felt supported and received supervision and annual appraisals.

Supporting people to eat and drink enough with choice in a balanced diet:
• People were supported to eat and drink enough.
• Some people required support with their meals. Care records showed how people's dietary needs were assessed, such as their food preferences and how they should be assisted with their meals. For example, one care plan stated, "I would like the carers to prepare me a hot drink, black coffee no sugar. I drink plenty of water. My [relative] prepares my meal."
• People told us they were supported with their dietary needs. A relative said, "[Relative] seems happy with the meals they cook for her, and I think they ask her what she would like." Another relative told us, "I buy

ready meals for [relative], and [staff] offer her a choice out of them all."
• Staff spoken with during our inspection confirmed they had received training in food hygiene and were aware of safe food handling practices when supporting people in their homes.

Staff providing consistent, effective, timely care within and across organisations:
• The service worked with other agencies and professionals to ensure people received effective care.
• Where people required support from other professionals this was supported and staff followed guidance provided by such professionals. Information was shared with other agencies if people needed to access other services such as GPs, health services, social services, advocacy services and older people organisations.

Supporting people to live healthier lives, access healthcare services and support:
• Where necessary, the service supported people and relatives with healthcare appointments and reviews.
• Staff were aware of what action to take if people were unwell or had an accident. They told us they would contact people's GP or phone for an ambulance as necessary and inform people's next of kin. One staff member told us, "We would report it immediately. We would call ambulance first and then the supervisor."
• People and their relatives told us they were supported with their health needs. One person said, "I'm diabetic, [and] can't see well. [Staff] know to keep a close eye on my feet. They always tell me if there's a problem." Another person commented, "Once [staff] phoned an ambulance for me because I was very unwell." A relative told us, "[Staff] pick up the early signs [of diagnosed health condition] before me, and we'll contact the doctor. They are hot on checking [relative] for any reoccurrence." Another relative commented, "Every morning they check [relative's] blood pressure as agreed with them. If they are concerned they'll immediately let me know, otherwise it's written in the [care records] for me to read."
• Records showed the service worked with other agencies to promote people's health such as district nurses, GPs, and pharmacists.

Ensuring consent to care and treatment in line with law and guidance:
The Mental Capacity Act 2005 (MCA) provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that, as far as possible, people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible.

• Staff ensured that people were involved in decisions about their care, and understood the procedures to make sure decisions were taken in people's best interests. One staff member told us, "We ask [people] before doing personal care. If you want to shower them and they say no, we will respect that." Another staff member said, "Ask permission. Suggest something. Decision always comes from the [person]." A relative told us, "If [relative] doesn't want a shower in the morning, they'll try him again later in the day."
• Mental capacity assessments were completed when there was any question of a person's capacity to independently make important decisions.
• We spoke to staff and found they had a good understanding of the principles of the MCA.
• Records showed people signed to consent however we saw that if a person was unable to sign documents, the provider had asked a relative to sign on behalf of the person when there was no evidence that the relative had a Lasting Power of Attorney (LPA). LPA accords the person who is given power of attorney the power to make decisions about your daily routine (washing, dressing, eating), medical care, and life-sustaining medical treatment. It can only be used if you're unable to make your own decisions.
• We spoke to the registered manager who told us they would follow up with people's relatives if their relative had a LPA in place. This meant appropriate consent was not always recorded when people lacked the capacity to make an informed decision, or give consent in accordance with Mental Capacity Act 2005

and associated code of practice.

We recommend that the service seek guidance and advice from a reputable source, in relation to recording appropriate consent in line with the Mental Capacity Act 2005 (MCA).

Good

Is the service caring?

Our findings

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

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

Ensuring people are well treated and supported; respecting equality and diversity:
• People and their relatives told us that staff were caring. One person said, "[Staff are] always so friendly and kind to me." Another person told us, "I think [staff are] all marvellous, so kind and attentive towards me. They feel more like friends than carers if I'm honest with you. I can't fault them at all. They don't mind what they do, and they'll always ask if I need anything else before they go." A third person said, "They do absolutely everything in a kind, friendly way. I don't think they could be any better to me." A relative told us, "[Relative] feels very comfortable with [staff], and they'll do anything for him. This is some months ago, but once a carer saw some chicken in the fridge which needed to be eaten up so she took it home and brought back chicken soup which she'd made. We thought that was wonderful."
• Staff showed a good awareness of people's individual needs and preferences. Staff talked about people in a caring and respectful way. One staff member said, "I treat [people who used the service] like how I would want to be treated. I treat them like my own grandmother or mum. We respect them like a person." Another staff member told us, "I have a good relationship with [people who used the service]. I treat them like I would treat my own parents but I still know my boundaries. Every day you get close to them." A third staff member commented, "I love my [people who used the service]. Whenever [people who used the service] need me I am always there for them. Even if not in my time I will still stay if they need me. I will inform the office and the family of course."
• We saw the service recorded compliments about the care provided. Comments included, "We just wanted to thank all the carers for the great care that they provided for [relative]. They were always very professional, caring and loving. They made a special bond with [relative] and even in the later stages of her life when she became very immobile were able to keep her smiling. You have a brilliant and professional team and you must be very proud of them" and "A very special thank you for all the love and outstanding care you all gave [relative]. The dedication you have all shown is unbelievable."
• Discussions with staff members showed that they respected people's sexual orientation so that lesbian, gay, bisexual, and transgender people (LGBT) could feel accepted and welcomed in the service. The registered manager told us, "[LGBT people] are like everybody. Find out what they like and what they want. How they would want to be looked after. It's about what they need, and what they want." A staff member said, "I have a [LBGT relative]. It doesn't matter to me. Everyone is individual as long as you try to be a good person."
• Training records showed staff had completed equality, diversity and inclusion training.

Supporting people to express their views and be involved in making decisions about their care:
• People were supported to express their views and to be involved, as far as possible, in making decisions about the care and support they received.
• Records showed people who used the service and relatives were involved in care planning and reviews.

One person told us, "In all my years of having care, I can't believe how good this lot are. When they came to assess me it was, 'What would you like us to do for you?' From day one it's all been about meeting my needs, being flexible, trying to help." One relative said, "[Care plan reviews] work well. We are involved in them, and they listen to our views and requests on his behalf." Another relative told us, "We've had two reviews with social services and the [service], including [registered manager]. [Relative] and I felt very much involved in it all. They kept asking us how we felt, were we happy etc."

• People and their relatives were involved in making choices about their care. One person said, "One week I asked if [staff member] could help me decorate my Christmas tree, she was so excited, and we had a great time doing that together. Couldn't have managed it on my own. They'll also help me change my duvet if I haven't been able to do it, all I've got to do is ask. They'd never say, 'That's not my job'. It means a lot to me that they're so easy-going." One staff member told us, "[People] have their own preferences and choices. We are there to encourage, lift them up and respect their preferences. [People] have changeable minds. Give them a chance to change their minds."

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

• People and their relatives told us their privacy and dignity were respected. One relative said, "[Staff] have a human side to them. I'd score them highly on that." Another relative told us, "I've never heard anyone being rough or unkind with my [relative]."

• Staff we spoke with gave examples about how they respected people's privacy. One staff member told us, "You have to respect each individual. When giving personal care, even though it's just the two of you, you have to cover the private parts, close the door, respect their preferences as well." Another staff member said, "As a carer they need our help but still try maintaining their dignity and privacy. I have a [person] bedbound. Before I enter the room, I ask if I can open the curtains and turn on the lights. They still need the respect. If giving personal care we should always say what we are going to wash."

• The service promoted people to live as independently as possible. Staff gave us examples about how they involved people doing certain aspects of their own personal care and day to day activities which supported them to maintain their independence. One staff member said, "I have a [person] who has dementia. She doesn't like help. I will say, 'will you come with me to change your bed?' I try and involve [person] as far as I can." Another staff member told us, "All people have the right to do what they want to do for themselves. We ask and give choice. We have to encourage people to do things for themselves when we know that they can. If you can see that they can still do it then why not. Not about being easy and quick but encourage people to do things for themselves otherwise they might deteriorate."

• People who used the service told us the service supported them to be independent. One person said, "[Staff] help me wash, but I do my front, and they do my back. I want to be as independent as I can be." A relative told us, "[Relative] is quite independent, and [staff] appreciate this."

• Promoting independence was reflected in people's care plans. One care plan stated, "[Person] to brush her teeth while carer runs shower. Assist [person] to shower, carer to prepare flannel with shower gel, encourage [person] to wash her front while carer washes her back. Encourage [person] to dry her front with hand towel. Carer to dry [person's] back."

Good

Is the service responsive?

Our findings

Responsive – this means that the service met people's needs

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

Personalised care; accessible information; choices, preferences and relationships:
• Staff showed us they knew people's likes, dislikes and preferences. They used this detail to care for people in the way they wanted. For example, care plans had clear details around how a person preferred to be supported with personal care and day to day tasks necessary to obtain desired outcomes. One care plan stated, "I enjoy reading and watching TV, I particularly like detective type shows. When I go out I like to go to the library and go shopping."
• People and relatives were positive about the person-centred care they received. One relative told us, "[Staff member] was sitting with [relative] holding his hand. They were both having a good laugh together. That meant such a lot to me. The way [staff] talk about my [relative], you can tell they're very fond of him, despite him being very difficult for them sometimes. I appreciate that they see beyond his dementia."
• All providers of NHS care or other publicly-funded adult social care must meet the Accessible Information Standard (AIS). This applies to people who use a service and have information or communication needs because of a disability, impairment or sensory loss. There are five steps to AIS: identify; record; flag; share; and meet. The service had taken steps to meet the AIS requirements.
• The care documentation clearly showed that the service identified and record communication impairments.
• The service supported people with communication impairments. One relative said, "[Staff] understand [relative] is visually impaired, so will introduce themselves to [relative] on arrival. They understand how important that it is to him." Another relative commented, "My [relative] is [hearing impaired], and I notice how they speak slowly and clearly to her. They just know how to help her." One staff member told us, "I have [person] really hard to understand what they are saying. Body language, pictures and signs helps us to communicate with each other. I have been with [person] for three years [and] now I just know and understand and interpret what they are saying. We ask the family because they know what the [person] wants. Sometimes the speech therapist will suggest flash cards." Another staff member said, "We have a [person] who is very [hearing impaired]. We [speak] nearer with her or use a notebook to communicate with her. It is in the care plan."
• People's cultural and religious needs were respected when planning and delivering care. Records showed people had discussions of their spiritual faith during the care planning process. One relative told us, "On a Sunday [staff] will ask if we're going to [place of worship]. [Staff] will always make sure we've got time to go."

Improving care quality in response to complaints or concerns:
• People's feedback, concerns, complaints and compliments were recorded.
• Staff knew how to provide feedback to the management team about their experiences which included supervision sessions and team meetings.
• People and their relatives were aware of how to make a complaint. A relative said, "I've got various phone numbers to ring, out of hours too, if I need to tell them anything, I've even got the manager's number. Their

communication with us is brilliant. I've no complaints, but I feel sure if I raised a problem with they'd take it very seriously."
• Records showed the service had received seven complaints for 2018. We found complaints were investigated appropriately and the service had provided a resolution to the complaints in a timely manner.

End of life care and support:
• The registered manager told us no one was receiving end of life care support at the time of our inspection.
• People were supported to make decisions about their preferences and staff supported people and relatives in developing end of life care plans. Other healthcare professionals such as GPs, district nurses and palliative care nurses were involved as appropriate.
• Staff gave us examples how they supported people with end of life care. One staff member said, "I have had the [end of life] training. It was emotional. I look at [people who used the service] as my own family. We must involve and listen to the family. Most [people] want to die at home. To have happy memories. To have dignity while they are still alive."
• The service had an end of life policy which was appropriate for people who used the service.
• Training records showed staff were up to date on end of life training.

Good

Is the service well-led?

Our findings

Well-Led – this means that service leadership, management and governance assured high-quality, person-centred care; supported learning and innovation; and promoted an open, fair culture

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

Planning and promoting person-centred, high-quality care and support with openness; and how the provider understands and acts on duty of candour responsibility:
• People and their relatives told us they felt the service was well run and responsive to their concerns and needs. One person told us, "They gave [staff member] unpaid leave to go [family emergency] but they've also given her an interim payment to pay her bills whilst she's away. That's why they have such good staff." A relative said, "I get on very well with [registered manager]. There's absolutely nothing that they could improve on, we're totally satisfied." Another relative told us, "[Registered manager] runs it efficiently, but flexibly. She's very accommodating, and will try hard to please us. She's great. She's a caring and thoughtful lady." A third relative said, "If I've ever contacted [registered manager] she will always get back to me. She's incredibly hard working and efficient. She's been out to see my [relative] a few times. She's well known by people. She doesn't sit in her ivory tower. She knows everything that goes on."
• Effective communication systems were in place to ensure that staff were kept up to date with any changes to people's care and support systems to staff. For example, staff meetings were held on regular basis. One staff member said, "Every month. We socialise. Like a mini reunion. Talk about any concerns and problems. They get resolved." Another staff member told us, "[Meetings] about the work or different issues."
• The service had a policy and an understanding of their responsibility of duty of candour. Duty of candour is intended to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong. The registered manager said, "[Duty of candour] is about transparency. For example, if there is an issue to be tackled I need to report to people who are involved like the police, the coroner, social workers and CQC."

Managers and staff being clear about their roles, and understanding quality performance, risks and regulatory requirements:
• Staff spoke positively about the registered manager. One staff member said, "[Registered manager] is very supportive. Because of her I stay here. She is the best." Another staff member told us, "[Registered manager] is very approachable."
• Staff were very positive about working for the service. One staff member told us, "It's good because in the office we are not just a [staff member], we are treated as a family. You can ask openly and they will help you." Another staff member said, "I always say I am proud of this company because we have a good working relationship. It's like a family. You can also approach the supervisors and [registered manager] as they are always willing to help you."

• The registered manager had a clear understanding of her role and the organisation. The registered manager told us, "I am most proud of my team because we are all united. I have managed to put all these great people together with all these differences. They do respect me and what I say matters to them and what they say to me matters."
• The service had a number of quality monitoring systems in place. These were used to continually review and improve the service.
• The registered manager told us they conducted an audit every month on the service. The audit looked at people's equipment, if daily logs were up to date, medicine records, infection control and home environment, and if people's home care folder was up to date.
• Spot checks were regularly conducted. The spot checks looked at staff member's appearance, communication skills, punctuality, interaction with family and client, daily notes, understanding of whistleblowing and safeguarding. Staff members and records confirmed this. One relative told us, "We've had a number of times in two years when they come out to talk with us, check we're happy, ask if they can do anything differently."
• The provider's head office conducted their own regular audit on the service. The audit looked at care files, staff files, safeguarding, medicines, complaints, training, out of hours, people's feedback, and recruitment.

Engaging and involving people using the service, the public and staff, fully considering their equality characteristics:
• The registered manager and the staff team knew people and their relatives well which enabled positive relationships to develop and good outcomes for people using the service. One relative said, "I have [registered manager's] direct number, which I try not to use, but she's so helpful always. Without a doubt I'd give them all ten out of ten."
• The quality of the service was also monitored through the use of a six-monthly survey to get the views of people who used the service and their relatives. Overall the results were positive. Comments included, "Carers are so good that my [relative] was in a depression and she is no longer depressed, her depression has lifted. Not only that but her whole life has changed for the better. Thanks is just not enough." and "We love your [staff] and [relative] loves them. They are very patient with her and cheers her [up] when [relative] gets depressed."
• The service ensured that care staff were highly motivated and offered care and support. The management and office team knew how important it was to appreciate the care staff.
• The service had a newsletter for the care staff which recognised and congratulated staff for their work.
• The service had a monthly award for care staff in appreciation of their work. The service's office had pictures of staff who had won the monthly award. The service had a yearly award and the care staff voted for the registered manager because of her support throughout the year.

Continuous learning and improving care:
• Throughout our inspection we saw evidence the provider and the registered manager were committed to drive continuous improvement.
• There was a quality assurance programme in place.
• The registered manager told us the service was always trying to improve the way they provided care. The registered manager said, "I have so many ideas I would like to implement and try. Learning is continuous."

Working in partnership with others:
• The service worked in partnership with key organisations to support care provision, service development and joined-up care. For example, the registered manager told us the service had worked with local dementia services, the local authority, social services, Clinical Commissioning Group, health services and advocacy services.